

**REQUEST AND AUTHORIZATION**

To: \_\_\_\_\_

Date of this request: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**This is a request and your authorization to furnish WHETSTONE MYERS PERKINS & FULDA, LLC, Post Office Box 8086, Columbia, South Carolina 29202, the medical records and care for \_\_\_\_\_, as indicated below:**

**Full Chart**

**Itemized Billing**

**Other** \_\_\_\_\_

\_\_\_\_\_

**The purpose of this request is for review by my attorneys. This authorization is valid for a period of one (1) year from the date of signing. I understand that I may revoke this authorization by written notice to WHETSTONE MYERS PERKINS & FULDA, LLC at any time during this period, except to the extent a source of information has already relied on it to take an action. I further understand that the information I am requesting may be subject to re-disclosure and may no longer be protected by the health information privacy provisions of 45 CFR part 164.**

**Expiration Date:** \_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_

**A photo copy of this authorization shall grant the same authority as the signed original.**

**Respectfully,**

**WHETSTONE MYERS PERKINS  
& FULDA, LLC  
601 Devine Street  
Post Office Box 8086  
Columbia, South Carolina 29202**