



South Carolina OB-GYN Associates, P.A.
 1333 Taylor Street, Suite 2-D | Columbia, SC 29201
 (803) 254.1300 or 799.BABY

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

 (Patient's Full Name at Time of Treatment) (Patient's Address, City, State, & Zip Code)

 (Chart # or Social Security #) (Patient's Date of Birth) (_____) (Patient's Telephone #)

 (Date(s) of Treatment) (Purpose of Release)

I authorize SC OB/GYN Associates P.A. to release my health information...

TO: _____
 (Recipient's Name, Address, City, State, & Zip Code)

Please mail record I will Pick Up (By exception only. Only YOU can pick up your records.)

INFORMATION TO BE RELEASED: (Please check all that apply)

- Diagnosis List / Patient Identification Lab Report(s) (type?) _____
- Physician Dictation (type?) _____ Office Notes (type?) _____
- Mammogram Report(s) Radiology Reports _____
- Billing Info (type?) _____ Other _____

REASON FOR TRANSFER: (Complete ONLY if you are transferring from our practice)

- Moving Dissatisfied with Practice Other _____
- Insurance is Out-of-Network (If so, list name of Insurance) _____

- =====
- 1.) I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.
 - 2.) I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.
 - 3.) I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the address noted at the top of this form.
 - 4.) I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
 - 5.) I understand the legal charge for obtaining the requested information can be \$.65 cents for the first 30 pages, \$.50 per page for all additional pages, and a \$15.00 clerical fee. (We only charge patients \$15.00)
 - 6.) I want this authorization to expire 90 days after signed, or by this date: _____.

Pre-Payment is Required for ALL Protected Health Information / Medical Records Copying

How would you like to pay? VISA MC AMEX DISCOVER CHECK

Card # _____ Exp Date _____ Security Code _____

 (Signature of Patient or Authorized Person) (Relationship of Authorized Person) (Date)

This form is used to release info FROM us to YOU