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) _____

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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 there may be a charge for the requested information.
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