***This form is used to release info " TO" SC OBGYN***

## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

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

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

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

***I AUTHORIZE*** _____
(Releasing Facility's or Provider's Name)

_____
( Address, City, State, & Zip Code)

***to RELEASE my health information*** **TO**: South Carolina Ob-Gyn Associates, P.A.
1333 Taylor Street, Suite 2-D
Columbia, SC 29201 **( SECURE FAX # 803-799-1635 )**

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

- ☐ ALL Medical Information
- ☐ Diagnosis List / Patient Identification
- ☐ Laboratory Report(s) (type?) _____
- ☐ Physician Dictation (type?) _____
- ☐ Office Notes (type?) _____
- ☐ Mammogram Report(s)
- ☐ Radiology Reports _____
- ☐ Billing Info (type?) _____
- ☐ Other _____

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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 will be sent to the address the info is being requested from.
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 obtaining the requested information.
6.) I understand that this authorization will expire 90 days after signed unless an earlier date is specified here: _____.

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

_____
(Relationship/Reason Patient is unable to sign)

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