Authorization of Records Release

I hereby authorize health information requested FROM:

Columbia Women's Healthcare
1301 Taylor Street
Suite 6-J
Columbia, SC 29201
Ph: (803) 254-3230 · Fax: (803) 779-9581

To disclose health information TO:

Facility or Provider's Name: ____
Address: ____
City: ______________________ State: ________ Zip: ______________
Phone: ______________________ Fax: ______________________

Authorization will expire: ______________________________

Purpose of request: (check all that apply)

□ Patient Request □ Treatment or Consultation □Billings or Claims Payment
□ Transfer □ Other (specify) ______________________________________

Type of Information Requested:

□ Entire Medical Record □ History & Physical □ Pap Smear
□ Consultation Reports □ Operative Reports □ Labs
□ Discharge Summary □ Progress Notes □ Pathology Reports
□ DEXA Report □ Other (specify): ______________________________

Right of the Patient:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Columbia Women's Healthcare. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

Patient Signature: ____ **Date**: ____________

Printed Name: ____

SSN: ______________________________ **DOB**: ______________________________