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tending to the unique nature of women

Date:

Records Release to Columbia Women's Healthcare

To: _____

I hereby authorize you to release to Columbia Women's Healthcare, L.L.C. any information including the diagnosis and records of any treatment or examinations rendered to me during the period from _____ to _____. **Authorization will expire on _____.**

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 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.

Social Security Number:	Signature
Witness	Address