



## Authorization of Records Release

### I hereby authorize health information requested FROM:

Facility or Provider's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### To disclose health information TO:

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

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: \_\_\_\_\_