Carolina Center of Gynecologic Oncology
Authorization for Use or Release of Information

Patient Name _______________ Date of Birth _______________

Patient Address _______________

I authorize Carolina Center of Gynecologic Oncology to use/release information on the above named patient.

_____**(RELEASE TO) disclose protected health information**
_____**(REQUEST FROM) use protected health information:**

Name of Provider _______________

Address _______________

____

Phone Number _______________ Fax Number _______________

Please send medical records to:
Carolina Center of Gynecologic Oncology
1470 Tobias Gadson Blvd., Suite 110
Charleston, SC 29407
Phone (843)556-4380 Fax (843)571-5531

Information to be used or disclosed: Entire Chart or Other (please list below)

____

Purpose of this disclosure: Continuation/Coordination of Care or Other (list below)

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This authorization shall be in force and effective until _______________ (termination date) or until the following event causes it to expire, _______________ (description of event)

I understand that I have the right to revoke this authorization at any time by sending a written notification to: Privacy Offi Carolina Center of Gynecologic Oncology, 1470 Tobias Gadson Blvd, Suite 110, Charleston, SC 29407. I understand that I have the right to inspect or receive a copy of the protected health information to be used or disclosed as described in this document by sending the request in writing to address above. I understand that a revocation is not effective in cases whe the information has already been used or disclosed but will be effective going forward. I understand that information use or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protecte by federal or state law. Any information received by this office for our own use will continue to be protected by the Feder Privacy Rule. I understand that I have the right to refuse to sign this authorization. I understand that my records will be sent via mail or fax.

____
Signature of Patient or Personal Representative

____
Date

____
Print or Type Name of Patient or Personal Representative

____
Description of Personal Representative's Authority (attach necessary documentation)