

**CAROLINA CENTER OF GYNECOLOGIC
ONCOLOGY, PA**

Authorization for Use and/or Release of Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____

Name & Address of Covered Entity Authorized to use and/or release information:

CAROLINA CENTER OF GYN ONCOLOGY- 1470 Tobias Gadson Blvd. Suite
110, Charleston, SC 29407 Phone: (843) 556-4380 Fax: 9843) 571-5531

The above named entity is authorized to: (Select both if applicable)

_____ Use protected health information for treatment, payment and operations.

_____ Disclose protected health information to the entity named below.

The use or disclosure of this information will result in direct or indirect remuneration to the practice named above from a third party. _____ Yes _____ no.

Name & Address of Entity to Receive Information (if applicable):

Description of information to be released

Date of Service _____ Service Provided _____

Describe in detail the level of information to be released _____

Permitted use of the described information

_____ Continuation/Coordination of Care

_____ Other as described _____

This authorization shall be in force and effect until: Date of Expiration _____(or)
Description of an event that will cause this authorization to expire. The event may relate to the
patient or the intended use or disclosure. _____

Rights of the Patient

I understand that I have the right to revoke this authorization at any time by sending a written
notification to: Debbie Buenting @ Carolina Center of Gyn Onc.
 1470 Tobias Gadson Blvd., Suite 110 Chas., SC 29407

I understand that a revocation is not effective in cases where the information has already been
used or 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. Any
information received by this office for our own use will continue to be protected by the Federal
Privacy Rule.

I understand that I have the right to inspect or copy the protected health information to be used or
disclosed as described in this document. I can do this by written notification to:
 Debbie Buenting @ Carolina Center of Gyn Onc.
 1470 Tobias Gasdson Blvd., Suite 110 Chas., SC 29407

I understand that my treatment will not be conditioned on signing this authorization.

I understand that I have the right to refuse to sign this authorization.

Date _____
Signature of Patient or Personal Representative

Print or Type Name of Patient or Personal Representative

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