

**CAROLINA CENTER OF GYNECOLOGIC  
ONCOLOGY, PA**

**Authorization for Use and/or Release of Information**

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**Patient Information:**

Name of Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

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**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

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**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.

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Description of information to be released**

Date of Service \_\_\_\_\_ Service Provided \_\_\_\_\_

Describe in detail the level of information to be released \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**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:     Scarlette Sipple @ 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 Gadson 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)