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:

_____

_____

_____

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):

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

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

_____ Coordination/Continuation of Care

_____ Other as described herein _____

_____

_____

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: _____

_____

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:

_____

_____

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)