Medical Provider's Name: Parkside Women's Centre
Street Address: 1518 Two Notch Rd, S.E.
PO Box 5669
Aiken, SC 29804
Phone and Fax: 803-649-7746 / 803-649-7730

Authorization for Release of Protected Health Information

Patient Name at time of treatment:

_____

Date of Birth:_____ Social Security Number: _____

Street Address: _____City: _____

State/Zip code _____

Telephone #: _____

I authorize the above named provider to release my protected health information to:

Recipient Name: _____

Street Address: _____
City/State/Zip code: _____

Fax information to: _____

Information for treatment period: From (date) _____ to (date)_____

Information to be released: (Please check all that apply)

☐	Patient History Forms	☐	Operative Notes	☐	Lab tests
☐	Office notes	☐	Imaging / CDs	☐	Hospital reports
☐	Pathology reports	☐	Imaging reports	☐	Other- specify

This information is being requested for the following purpose (s): _____

Sensitive Information: I understand that my record may include information relating to AIDS or HIV, psychiatric care, psychological assessment, behavioral and/or mental health services, sexually transmitted diseases, alcohol and/or drug abuse and this information will be released.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing to the above medical provider and that the revocation will not apply to information already released based on this information.

Expiration: I understand that this authorization will expire 12 months after signed unless an earlier date is specified here: _____

Services: I understand that refusal to sign this authorization cannot be used as a reason for denial of services or benefits.

Please be aware that if you request that your records be sent to another OBGYN in this area, we will consider it a transfer of care. Therefore, if you should call in the future for an appointment, we will be unable to see you.

_____ _____
Signature of Patient or Legal Representative Date