Authorization for Release of Medical Records FROM Bon Secours Upstate OB/GYN

Patient Name: _____

Address: _____

DOB: ____/____/____ Social Security Number: _____ Ph # _____

This is my written authorization for:

Bon Secours Upstate Obgyn Group
124 Verdae Blvd., Suite 204
Greenville, SC 29607
(864) 271-9780 Phone (864) 271-9785 Fax

To **RELEASE** Information **TO**:

The Office of Dr: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

- Release Format: ◯ To Mail ◯ To Fax ( ) To Pick Up on_____

Information to be Released:

◯ All Medical Records ◯ Lab Reports ◯ Dr Notes
◯ Prenatal Records ◯ X-Ray/Ultrasound ◯ Hospital
◯ Demographics ◯ Insurance ◯ Other: _____

Purpose of Disclosure:

◯ Changing Physicians ◯ Moving ◯ Referral
◯ Insurance Claim ◯ Legal ◯ Other: _____

I understand that these records may include information on sexually transmitted diseases, AIDS, HIV, mental, health, alcohol/drug abuse.

◯ **YES**, I authorize the release of this information. ◯ **NO**, I do not authorize the release of this information.

REVOCATION: I understand this authorization may be revoked in writing at any time. Unless otherwise indicated, this authorization will expire 90 days from the date of signature. The physician and the employees are released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian: _____ Date: _____