

# M A G N O L I A

– O B / G Y N –

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## Authorization of Use and Disclosure of Protected Health Information

Date: \_\_\_\_\_

Account #: \_\_\_\_\_

NAME: \_\_\_\_\_

Maiden/AKA (If Applicable) \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Phone #: \_\_\_\_\_

I Authorize:

**MAGNOLIA OB/GYN LLC**  
PO Box 70910  
MYRTLE BEACH, SC 29572  
PHONE: (843) 449-5848  
FAX: (843) 449-8595

To Release my Records to:

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

\_\_\_\_\_ Entire Medical Record

\_\_\_\_\_ Other (Please specify): \_\_\_\_\_

Reason for Release of Records: \_\_\_\_\_

This Authorization is effective through \_\_\_\_\_ unless revoked or terminated in writing by the patient.

Information that is disclosed under this Authorization may be disclosed again by the organization/person to which it is sent. The privacy of this information may not be protected under the Federal Privacy Regulations.

I understand that the information in my health record may include information relating to sexual transmitted diseases, AIDS or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

Magnolia OB/GYN LLC cannot require me to sign this Authorization in order to receive treatment.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_