MAGNOLIA
– OB/GYN –

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Authorization of Use and Disclosure of Protected Health Information

Date: _____ Account #: _____

Name (Last, First, MI) Maiden/AKA (If Applicable)

DOB: _____ SS#: _____ Phone #: _____

I Authorize: Physician's Name: _____

Address: _____

_____

Phone: _____

Fax: _____

To Release my Records to: **Magnolia OB/GYN LLC**
170 VILLAGE CENTER BLVD
MYRTLE BEACH, SC 29579 PHONE:
(843)449-5848 FAX: (843) 449-8595

_____ 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 metal 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: _____