Coastal Carolina OB/GYN
620 Singleton Ridge Road
Conway, SC 29526
Telephone: (843) 349-0100 | Fax (843) 349-0104
coastalcarolinaobgyn.com

I AUTHORIZE RELEASE AND DISCLOSURE OF THE FOLLOWING HEALTH CARE INFORMATION FROM THE FOLLOWING FACILITY TO COASTAL CAROLINA OBGYN:

Facility/Physician: _____

Address: _____

City, State, Zip Code: _____

Telephone/Fax: _____

_____Complete Medical Record
_____Only Certain and Specific Information (specify)_____
_____Prenatal Record (to include all lab results and ultrasound results)
_____Last Pap Smear Results
_____Last Mammogram Results
_____Other (specify)_____

Date of care included: _____to _____

I AUTHORIZE THIS INFORMATION TO BE RELEASED AND SENT TO:

COASTAL CAROLINA OBGYN
PO BOX 50754
MYRTLE BEACH, SC 29579
TELEPHONE: 843-349-0100 | FAX: 843-349-0104

Expiration Date: This authorization will expire on (date or event) _____
(If no date or event is stated, expiration is six months from the date it was signed.)

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that this authorization may be revoked in writing by myself and delivered to Coastal Carolina OBGYN,LLC at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Patient Name: _____
DOB: _____ SSN: _____
Patient Phone Number: _____
Patient Signature: _____ Date: _____
Witness Signature: _____ Date: _____