Highlands
CENTER FOR WOMEN
OBSTETRICS & GYNECOLOGY

Highlands Center for Women, PA

Authorization To Release Medical Information

Patient Name: _____ Date of Birth: _____

Social Security Number:_____ Phone Number: _____

COMPLETE ADDRESS:_____

I HEREBY AUTHORIZE HIGHLANDS CENTER FOR WOMEN, PA TO [ ] RECEIVE [ ] RELEASE MY RECORDS FROM/TO:

Facility, Doctor, or Person_____

Address: _____

Phone #: _____ Fax #: _____

INFORMATION TO BE RELEASED:

_____Complete Medical History (Three years of medical records will be provided unless other wise requested.)
_____Medical Records for the period of_____ to _____
_____Other _____

THIS DISCLOSURE IS BEING REQUESTED FOR THE FOLLOWING REASON:

☐ Continuing Care ☐ Transfer of Care ☐ Worker's Compensation Case
☐ Legal Action ☐ Insurance/Disability Coverage ☐ Personal Reasons ☐ Other

RELEASE MY MEDICAL RECORDS TO:

Highlands Center for Women, PA
105 Halton Village Circle Ste. A
Greenville, SC 29607
Phone: 864.234.1433/ Fax 864.286.1462

By signing this authorization, I authorize and permit the above designated provider and staff members to use and/or disclose certain protected health information (PHI) about me to the party listed above. This authorization permits the designated facility to disclose the PHI described above. **This authorization expires TWENTY years from date signed, unless other period is designated: _____ (initials).** I understand that I have the ability to revoke this authorization by providing the practice with a written revocation unless the practice has already disclosed the PHI relying upon this authorization. Should I desire to revoke this authorization, my revocation must be in writing and sent to **Highlands Center for Women, P.A., 105 Halton Village Circle Suite A, Greenville, SC 29607**. I understand that the PHI disclosed pursuant to this authorization may no longer be protected by a federal privacy law. I further understand that Highlands Center for Women, P.A. will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits, if applicable, based on the execution of this authorization and that my participation is voluntary. Patients requesting copies of their PHI for personal reasons will be charged. Copying fees will apply to, but are not limited to, legal actions and insurance disability forms. Payment is due prior to PHI being released. Copying fees do not apply to other medical providers or healthcare facilities that receive PHI directly.

PATIENT'S SIGNATURE:_____ DATE:_____

or SIGNATURE OF LEGAL REPRESENSATIVE _____

RELATIONSHIP ☐Legal Guardian ☐Certified personal representative
☐Power of Attorney for Healthcare ☐Other

Witness: _____ Date: _____