



Office Address:
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Telephone: 843-449-3381
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Endoscopy Center:
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Myrtle Beach, SC 29572
Telephone: 843-839-2581
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AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

Address: _____

I authorize _____ to disclose my "protected health information" (PHI) to:

Recipient name Address City State Zip Code

Information for treatment date: From _____ To _____

Information Requested:

- Discharge Summary Office notes Other:
Lab Reports Pathology report
EGD Reports Colonoscopy report
Radiology Hospital Consult

Purpose: Legal Investigation Insurance Disability Determination Continuum of care Other:

- A. I understand that PHI may include records disclosed by health care providers and facilities that previously provided treatment to me.
B. I understand that I may revoke this Authorization at any time except to the extent that action has been taken in reliance upon it.
C. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under Federal Privacy Standards.
D. I understand that this Authorization will expire 90 days after it is signed unless other date is specified.

I have read and understand this authorization. I certify that I am the Patient listed above or a person authorized to permit release of records on the Patient's behalf. I hereby release the Provider (as named above) from any liability or damages arising in connection or related to with the use and/or disclosure of my protected health information pursuant to this authorization.

Print Patient Name Patient Signature Date

Authorized Representative Relationship to Patient Telephone #

COMMENTS: