STRAND GI ASSOCIATES
ENDOSCOPY CENTER

Office Address:
7900 N. Kings Hwy., Suite A
Myrtle Beach, SC 29572
Telephone: 843-449-3381
Fax: 843-449-9721

Endoscopy Center:
7900 N. Kings Hwy., Suite B
Myrtle Beach, SC 29572
Telephone: 843-839-2581
Fax: 843-839-2585

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: