The Medical Group Urology

AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: ________________________________ Date of Birth: ______________

Address: ____

Phone Number: ______________________ Fax Number: ______________________

I have been a patient of your office (or am the patient's authorized representative) and I understand that the practice provider has legally protected health information about me (or the person I represent) that I wish to transfer.

PROVIDER THAT HAS YOUR RECORDS

I, ______________________________ hereby authorize the provider to release my records:

Practice:

Physician:

Address:

Phone:

Fax:

PROVIDER YOU WANT TO RECEIVE YOUR RECORDS

The Medical Group Urology—Dr. David Horger
701 Medical Park Drive, Suite 110
Hartsville, South Carolina 29550

Phone: (843) 656-1204

Fax: (843) 656-1212

Please transfer and/or disclose the following information:

☐ All medical records, files, charts, reports and other associated health information

☐ Other (specify): ____

- I understand that I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.
- A photocopy or scanned image of this authorization may be used in lieu of the original.

________________________________ ______________

Signature of Patient Date

If signed by a personal representative of patient, print name and relationship to patient:

________________________________ ______________

Name of Patient (Please Print) Relationship