Grande Dunes ObGyn & Facial Aesthetics

1021 Cipriana Dr. Suite 250
Myrtle Beach, SC 29572
Office: (843) 839-2229 Fax: (843) 839-2230

Authorization to Release Health Information to a Health Care Provider

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Patient Information:

Name:____Social Security #:_________________________

Address:____City:____

State:____Zip Code:__________________________________

ENTITY AUTHORIZED TO RELEASE INFORMATION:

GRANDE DUNES OBGYN & FACIAL AESTHETICS
DR. TATIANA VU-MOLASCHI
1021 CIPRIANA DR. SUITE 250
MYRTLE BEACH, SC 29572
OFFICE: 843-839-2229 FAX:843-839-2230

INCLUDE THE FOLLOWING INFORMATION TO BE USED FOR PATIENT CARE:

ENTIRE MEDICAL RECORD_____ LAB RESULTS_____

OTHER:____

FORWARD INFORMATION TO:

PHYSICIAN NAME:____

ADDRESS:____

OFFICE NUMBER:____FAX NUMBER:_____________________________

THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL THE INFORMATION HAS BEEN FORWARDED AS REQUESTED

RIGHTS OF THE PATIENT

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address above and that a revocation is not effective if the information has already been disclosed, but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to the privacy officer of this practice.

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Signature of Patient or Personal Representative ______________________ **Date** ______________________