Island Women's Care

Christine S. Gerber, MD, FACOG
Caroline G. Millan, MD, FACOG

56 Business Center Dr
Pawleys Island, SC 29585
Phone 843-235-1222
Fax 843-314-4020

INFORMED AUTHORIZATION AND CONSENT FOR THE RELEASE OF MEDICAL RECORDS

I HEREBY AUTHORIZE ISLAND WOMEN'S CARE TO RELEASE AND/OR OBTAIN MEDICAL RECORDS FOR:

_____ DOB:_____
(PRINT PATIENT'S NAME)

( ) RELEASE TO ( ) OBTAIN FROM

_____ _____

_____ _____

_____ _____

FOR THE PURPOSE OF: CONTINUITY OF CARE

INFORMATION TO BE DISCLOSED:
( )MEDICAL NOTES/SUMMARY ( ) OPERATIVE/PROCEDURE REPORTS ( ) ANNUAL VISIT

( )PAP/HPV TYPE ( ) MAMMOGRAM REPORT ( )PELVIC SONO ( )BONE DENSITY ( )RECENT LAB

( )PATHOLOGY ( )ALL MEDICAL RECORDS –LIMIT TO LAST 2 YEARS OF DOCUMENTATION

I UNDERSTAND THAT THESE MEDICAL RECORDS MAY OR MAY NOT CONTAIN INFORMATION PERTAINING TO PSYCHIATRIC COUNSELING OR TESTING, ALCOHOL OR DRUG ABUSE COUNSELING OR TESTING, AND/OR HIV/ARC TESTING. I DO EXPRESSLY AND VOLUNTARILY AUTHORIZE THE DISCLOSURE OF THE SAID MEDICAL RECORDS TO THE PERSON (S) AND OR/ENTITIES AS STATED ABOVE. I UNDERSTAND THAT INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE PRIVACY LAWS. THIS AUTHORIZATION/CONSENT WILL REMAIN IN EFFECT FOR A PERIOD OF ONE YEAR FROM THE DATE OF SERVICE STATED BELOW, UNLESS OTHERWISE REVOKED IN WRITING BY THE PERSON TO WHICH IT PERTAINS, TO THE MEDICAL RECORDS DEPARTMENT. THIS REMAINS IN EFFECT FOR ONE YEAR FROM THE DATE SIGNED.

_____ DATE:_____
ATIENT, PARENT, LEGAL GUARDIAN, OR LEGALLY AUTHORIZED AGENT