

## MEDICAL RECORDS RELEASE AUTHORIZATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

PLEASE RELEASE ALL MEDICAL RECORDS FROM **2020-PRESENT** FOR TRANSFER OF PATIENT CARE

**\*\*\*\*\*PLEASE DO NOT FAX MORE THAN 30 PAGES AT A TIME\*\*\*\*\***

FROM: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**TO: Vida Gynecology**

**Fax: 864-720-1300**

**Phone: 864-720-1299**

**Address: 330 C Pelham Road Ste A  
Greenville, SC 29615**

Please release a copy of all medical records, including but not limited to all records, progress notes, operative notes, laboratory/x-ray results, and diagnostic tests. This authorization is valid from the date of this document and will expire 180 days after that date.

BY MY SIGNATURE I AUTHORIZE THE RELEASE OF ALL MEDICAL RECORDS and agree that I have been offered a copy of this document as it is available in the office of Vida Gynecology as well as online at [www.vidagyn.com](http://www.vidagyn.com).

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

Rights of the patient: I understand that I have the right to revoke this authorization at any time by sending notification to Vida Gynecology 330 C Pelham Road Ste A, Greenville, SC 29615. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that my treatment, payment, enrollment, or eligibility is not dependent on whether I sign this authorization. I understand that information used or disclosed because of this authorization may result in redisclosure by the recipient and may no longer be protected by federal or state law. Information received by this office is for its own use and will continue to be protected by our Privacy Policy. I understand that I have the right to inspect or copy the protected health information disclosed as described in this document. I can do this by written notification to Vida Gynecology. I understand that I have the right to refuse to sign this authorization.