Dion L. Franga, MD, FACS, RPVI
Sandra Chaplin, ACNP & Cortney Herndon NP-C
3045 Saint Matthews Road
Orangeburg, SC 29118
Phone 803-747-7242 **Fax** 803-747-7243

AUTHORIZATION TO RELEASE
YOUR SOUTH CAROLINA SURGICAL MEDICAL INFORMATION TO SOMEONE

Patient Name:_____ **Birth Date:**_____

Address, city, state, and zip code: _____

_____Phone number: _____

Requesting my protected health information **from** South Carolina Surgical be released **to**:
_____

Address, city , state, city, Zip Code: _____
_____

RELEASED INFORMATION REQUESTED:

- ☐ Any/all medical records
- ☐ Surgical procedures
- ☐ Labs, ekg and diagnostic tests
- ☐ Admission and Discharge records .
- ☐ Specific records relating to the following: _____

- The above information is strictly confidential and will be used in my best interest.
- I have the right to revoke this authorization in writing at any time.
- I have a right to inspect and/or receive a copy of the authorization and/or information that has been released. Records released directly to the patient there may be a charge.
- I understand this authorization will automatically expire in one year.

Patient or legal representative:

Print name: _____

Signature: _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____

3/2/21 SC

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AUTHORIZATION TO RELEASE
YOUR MEDICAL INFORMATION TO SOUTH CAROLINA SURGICAL

Patient Name:_____ **Birth Date:** _____

Address, city, state, and zip code: _____
_____Phone number: _____

Requesting my protected health information **from** the following physician/facility:
Address, city, state, city, zip code: _____

_____

Be released **to** South Carolina Surgical

RELEASED INFORMATION REQUESTED:

- ☐ Any/all medical records
- ☐ Surgical procedures
- ☐ Labs, ekg and diagnostic tests
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Witness: _____ Date: _____

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