Elite Gynecology, LLC
Authorization for Release of Protected Health Information

<table>
<tr><td>Legal Name:</td><td>Date of Birth:</td></tr>
<tr><td>Address:</td><td>SSN:</td></tr>
<tr><td colspan="2">City, State, Zip:</td></tr>
<tr><td>Best Contact Number:</td><td>[ ] home [ ] cell [ ] work</td></tr>
<tr><td colspan="2">Email :</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Dates of Treatment to be Released:</td></tr>
<tr><td colspan="2">Purpose of Release:
[ ] Individual Use [ ] Continued Patient Care [ ] Insurance [ ]Legal
Other________________________________</td></tr>
<tr><td>Request Information From:

Practice Name:______________________________
Provider Name:______________________________
Address:____________________________________
City/State/Zip________________________________
Ph #:____________________Fax#:_______________</td><td>Send Information To:

Practice Name: Elite Gynecology
Provider Name: Dr. Michelle Gee
Address:_1 Wellness Blvd, Suite 102
City/State/Zip: Irmo, SC 29063
Ph # 803-638-3946 Fax 866-632-6908</td></tr>
<tr><td>Information to Be Released:

[ ]Office Notes [ ] Progress Notes
[ ] Laboratory Reports [ ] Radiology Reports
[ ] Entire Record
Other:______________________________</td><td>Delivery Method:

[ ] Mail [ ] Pick Up [X] Fax
[ ] Secure Email [ ] Other__________________</td></tr>
</table>

Patient Rights: I understand that :

- I can cancel this permission at any time. I must cancel in writing and send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to the information not yet released by the facility or practice.
- This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2) genetics, HIV/AIDS , and other sexually transmitted diseases.
- Once my health information is released the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in a health plan, or eligibility for benefits.
- Elite Gynecology will not share or use my information without my permission other than by ways listed in the Notice of Privacy Practices or as required by law.
- A fee may be charged for providing the protected health information.
- I have a right to receive a copy of this form upon request.

This permission expires one year after the date of my signature unless an earlier date is written here.________________

Patient Name: ____Signature:____
Date:______________________