Ardra Davis-Tolbert, MD
Claude Tolbert, MD
Erin Eckard, MD
JoAnn Csakany, MD
Halle Welch, CNP

riverside women's care

Lynn Norton, MD
Meredith Mitchell, MD
Jaime Cuff, FNP
Erica Downey, MD

**Date:** _____ **SSN:** _____

**Patient Name:** _____ **DOB:** _____

**I hereby authorize: (Name, address, phone and fax numbers of releasing facility)**

_____

_____

_____

**To release to: (Individual name, facility/organization, address, phone and fax numbers)**

_____

_____

_____

**Purpose of Disclosure**

☐ Continuing Care ☐ Legal

☐ Personal Use ☐ School

☐ Other: _____ ☐ Payment of Claim

**I specifically authorize the release of information relating to:**

☐ Substance Abuse (Including alcohol/drug use)

☐ Behavioral Health

☐ HIV related information (AIDS related testing)

**Information to be released to include all dates and all records including but not limited to:**
Discharge Summary, H&P Exam/Initial Evaluation, Consults, Counselor/Therapist Summary, Progress Notes/Provider, Orders, X-Ray Reports, X-Ray Films/MRI, Bone Density/Mammography Reports, Diagnostic Test, ☐ Other: _____

**ACKNOWLEDGEMENT OF UNDERSTANDING**

I understand the expiration date of this authorization is one (1) year. I understand I may revoke this authorization at any time by notifying the providing organization in writing and it will be effective on the date notified except to the extent that action has already been taken by the recipient and no longer be protected by Federal privacy regulations. I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care.

_____ _____ _____

Patient or Personal Representative Relationship Date

13 Marshellen Drive ● Beaufort, SC 29902 ♦ 75 Baylor Drive ● Suite 200 ● Bluffton, SC 29910
P. 843-540-5857 ● F. 843-524-5655