Sandhills OB-GYN Associates, P.A.

Jonathan O. Nwanagu, M.D.
Board Certified by the
American Board of
Obstetrics & Gynecology

Compound Authorization for Release of Information

This authorization form permits Dr. Jonathan Nwanagu, Sandhills OB/GYN, Associates, P.A. (P.O. Box 7481, Columbia, SC 29202) to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name: _____ Birth Date: _____

Receiving Entity: Please indicate those entities or persons you wish to get the described information about you.	**Description of information to be given to corresponding Entity or Person.**
Voicemail #	Appointment Time Results of lab test or x-rays Other
Spouse (Provide name)	Financial information Medical information - please list
Parent (Provide name)	Financial information Medical information - please list
Other (Provide name)	Financial information Medical information - please list

Purpose

The purpose of this authorization is to meet the patient's request for information disclosures and uses. **Expiration date or event:** This authorization shall be enforced until revoked by the patient or _____.

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the bottom of this form. 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 information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____Date_____Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation): _____

_____ _____ _____

Patient/Legal Guardian Name Printed Witness Signature Date