Medical Records Release
Cile H Williamson MD Gynecology
3 Regional Cr Suite B
Pinehurst NC 28374
910.215.0111
Fax 910.215.0113

Patient Name: _____ Date of Birth: _____
Address:_____ SS# _____
_____

Medical Record Number: _____ Phone #: _____
I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below: I, _____, hereby authorize _____
to release the following information:

___Lab & Xray reports ___OP reports ___H & P ____D/C Summary
___Emergency report ___Pathology report ____Clinic notes
___Entire chart

I do ___ I do not ___ authorize release of information related to AIDS or HIV infection, sexually transmitted diseases, psychiatric care and or psychological assessment, and treatment for alcohol and/or drug abuse.

Release information to: Dr Cile Williamson
3 Regional Cr Ste B
Pinehurst NC 28374

Authorized Private Health Information will be used and disclosed for the following purposes:

- ☐ I have received a copy of Cile H Williamson MD Gynecology's Notice of Privacy Practices.
- ☐ I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment payment, enrollment in a health plan or eligibility for benefits. I also understand my signature will be required prior to my request being completed.
- ☐ Cile H Williamson MD Gynecology may use or disclose such protected health information only until expiration date or expiration event relating to the individual or purpose of the use or disclosure.
- ☐ At all times, I retain the right to revoke this authorization. Such revocation must be submitted in writing to Cile H Williamson MD Gynecology, 3 Regional Dr Suite B, Pinehurst NC 28374.
- ☐ I understand that information used or disclose pursuant to this authorization may be subject to re-disclosure by the recipient of such information, and, at that point, the information may no longer be protected under the federal or state confidentiality rules.
- ☐ This authorization will automatically expire six months from the date signed.
- ☐ I understand that I may be required to pay a fee for copying these medical records.

I have read and understand this information. I have received a copy of this form and I am the patient or am authorized to act on behalf of the patients.

Signature of Patient: _____ Date: _____
Signature of Witness: _____ Date: _____