



PIEDMONT REPRODUCTIVE ENDOCRINOLOGY GROUP

authorization for release of
MEDICAL RECORDS

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I AUTHORIZE THAT MY MEDICAL RECORDS BE SENT:	TO <input type="checkbox"/>	FROM <input type="checkbox"/>	THE BELOW OFFICE
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- | | | | | |
|---|---|--|--|---|
| <input type="checkbox"/> GREENVILLE
17 Caledon Court
Suite C
Greenville, SC 29615
P: (864) 232.7734
F: (864) 232.7099 | <input type="checkbox"/> SPARTANBURG
1330 Boiling Springs Road
Suite 2200
Spartanburg, SC 29303
P: (864) 583.2669
F: (864) 583.2459 | <input type="checkbox"/> ASHEVILLE
76 Peachtree Road
Suite 210
Asheville, NC 28803
P: (828) 210.8284
F: (828) 350.7516 | <input type="checkbox"/> COLUMBIA
2324 Sunset Blvd.
W. Columbia, SC 29169
P: (803) 726.3600
F: (803) 929.0504 | <input type="checkbox"/> LOWCOUNTRY
5500 Front Street
Suite 410
Summerville, SC 29486
P: (843) 881.7400
F: (843) 881.7444 |
|---|---|--|--|---|

	TO <input type="checkbox"/>	FROM <input type="checkbox"/>	THE FOLLOWING
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PRACTICE, INDIVIDUAL, OR ORGANIZATION _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____ FAX _____

patient information

NAME _____ SSN _____

DATE OF BIRTH _____ TELEPHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

This authorization places no restrictions on any information to be released. If any restrictions are to be placed on information being released, please state:

SIGNATURE OF PATIENT _____ DATE _____

WITNESS _____ DATE _____

This authorization expires one year from date signed