Authorization- Compound
(Front and Back)

Please complete this form to allow us to speak to your family, employer, or anyone else indicated by you on this form. This will also allow us to leave you voicemails or contact you through the patient portal. We are only able to contact the persons in the areas that you fill out in both the left and right column. If you leave this blank, we can call you, but will be unable to leave messages.

This authorization form permits:
Name: Laurel Endocrine and Thyroid Specialists, PA
Address: 1740 St. Julian Place
City/State/ Zip: Columbia, SC 29204
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 _____
Address _____
City/State/ Zip _____

Receiving Entity: Please check the boxes for those entities or persons you wish to get the described information about you.	Description of information to be given to checked Entity or Person.
Voicemail Home #_____	☐ Appointment time ☐ Results of lab test or x-rays ☐ Other _____
Voicemail Cell phone #_____	☐ Appointment time ☐ Results of lab test or x-rays ☐ Other _____
Employer _____ School _____	☐ Appointment or absentee information ☐ Return to work or school information
Spouse (Provide name) _____	☐ Family billing information ☐ Financial information ☐ Medical information- please list _____ ☐ _____
Parent (Provide name) _____	☐ Family billing information ☐ Financial information ☐ Medical information- please list _____ _____
Other (Provide name) _____ Relationship _____	☐ Financial information ☐ Medical information- please list _____ _____
Other (Provide name) _____	☐ Financial information ☐ Medical information- please list _____ _____

Relationship _____	
Patient Portal	☐ Appointment time ☐ Results of lab test or x-rays, medical information

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 enforce until revoked by the patient or _____

Verification method or code: This practice will verify the identity of any entity requesting protected health information. Verification information may include:
_____

Rights of the Patient

All previous authorization forms will be revoked.

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 top 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 (as defined by HIPAA)

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

_____

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Office Use Only:

Receiving Employee_____ Date received____

☐ Copy given to patient

Form Updated 05/05/17