LAUREL ENDOCRINE AND THYROID SPECIALISTS, P.A.
1740 ST. JULIAN PLACE
COLUMBIA, SC 29204
PHONE (803) 256-3534
FAX (803) 254-7032

Authorization to Disclose Health Information

Patient Name: _____

Date of Birth: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the released information may no longer by protected by federal privacy regulations.

Purpose of Release:

Medical Care: _____ Legal Representation: _____ Other (specify): _____

Requesting Information From:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Type of Information Requested:

Office Notes _____ Recent Hospitalization_____ Laboratory Results _____

X-ray & Imaging Reports _____ Pathology Reports _____ Entire Record _____

Dates: From: _____/_____/_____ To: _____/_____/_____

I understand that I have a right to revoke this authorization at any time. I must revoke this authorization in writing to the privacy officer of this practice. If I revoke this authorization, I understand that the revocation will not apply to information thhat has already been released. Unless otherwise revoked, this authorization expires upon fulfillment and delivery of the information requested.

_____ _____

Signature of Patient/Legal Representative Date