LAUREL ENDOCRINE AND THYROID SPECIALISTS, P.A.
1740 ST. JULIAN PLACE
COLUMBIA, SC 29204
PHONE (803) 256-3534
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Authorization to Release Health Information About Patient

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): _____

Release Information To:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Release the following information at the patient's request:

Financial: _____ Health: _____ Other (specify): _____

_____

_____

Information to be: Mailed _____ Faxed: _____ Picked Up: _____

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 will remain in effect until revoked by the patient.

_____ _____

Signature of Patient/Legal Representative Date