LAUREL ENDOCRINE & Thyroid Specialists, PA

1740 St. Julian Place Columbia, SC 29204
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PATIENT AUTHORIZATION FOR PERSONAL REPRESENTATIVE

Patient Name: _____

Address: _____ City: _____ ST: _____ Zip:_____

Birthdate: _____/_____/_____ Home phone: (_____)_____ Work Phone: (_____)_____

Purpose of Request
I authorize the Practice to disclose or provide my protected health information to the following individual, who is authorized to act as my personal representative for the purposes of receiving all of my protected health information. I will inform my personal representative of the last four digits of my social security for identification purposes when inquiring about my health information. As my personal representative, they may exercise my right to inspect, copy, and request amendments to my protected health information. They may also consent or authorize the use or disclosure of my protected health information:

Personal Representative:

_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number
_____	_____	_____
Name	Relationship	Phone Number

Description of Information to be Disclosed
I authorize the Practice to disclose all of my protected health information to my designated personal representative.

Expirations or Termination of Authorization
This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.

Right to Revoke or Terminate
As stated in our Privacy Notice, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

Laurel Endocrine and Thyroid Specialist
Attn: Privacy Manager
1740 St. Julian Place
Columbia, SC 29204

Re-Disclosure
I understand the Practice has no control over the person(s) I have listed as my personal representative. Therefore, any protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the Practice.

Patient Signature: _____ **Date:** _____