CAROLINA ENDOCRINE ASSOCIATES

Authorization for Release of Protected Health Information

Patient Full Legal Name: _____Date of Birth: _____

Street Address: _____Social Security #: _____

City, State, Zip: _____Best Contact #: _____

RELEASE INFORMATION FROM: Carolina Endocrine Associates, LLC		RELEASE INFORMATION TO:	
843-863-0088	843-764-1740		
Phone Number	Fax Number	Phone Number	Fax Number

DATES OF TREATMENT OR DATE RANGE OF RECORDS TO BE RELEASED:
From: _____ To _____

PHYSICIAN PRACTICE INFORMATION TO BE RELEASED: (Check All That Apply)
☐ Office/Clinic Summary ☐ Progress Notes ☐ Laboratory Notes ☐ Radiology Reports
☐ Other: _____ ☐ Entire Record (not including psychotherapy notes)

DELIVERY METHOD: ◯ Regular U.S. Mail ◯ Pick Up ◯ Fax ◯ Secure Email
◯ Other: _____

Patient's Rights- I Understand that:
..I can cancel this permission at any time. I must cancel in writing or send or deliver the cancellation to the releasing facility or practice named above. Any cancellation will apply only to information not yet released by the facility or practice.
..This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR part 2), genetics, HIV/AIDS, and other sexually transmitted diseases.
..Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.

This permission expires one year after the date of my signature unless an earlier date or event is written here: _____

Print Name: _____ Patient Signature: _____

2881 Tricom Street, Suite A
Charleston SC 29406

843-863-0088 Phone 843-764-1740 Fax