



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 #: _____

Table with 2 columns: RELEASE INFORMATION FROM and RELEASE INFORMATION TO. Includes contact details for Carolina Endocrine Associates, LLC such as phone numbers 843-863-0088 and 843-764-1740.

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