WELCOME TO LANCASTER ENDOCRINOLOGY

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410 S. Herlong Ave. Ste. 106
Rock Hill, SC 29732

HIPAA RELEASE OF INFORMATION

Patient Name:____ Date of Birth:_______________________

I hereby authorize the release of my medical records medication history to the physicians at Lancaster Endocrinology
It is frequently necessary for personnel at Lancaster Endocrinology to communicate lab results, radiology results, instructions, information about treatment, and other items of Protected Health information with our patients. In the event that our staff is not able to speak with you (the patient) directly, please give us instructions regarding communication with you. WE WILL NOT GIVE OUT ANY INFORMATION UNLESS YOU INDICATE BELOW:

Consent to release information to patient:

Consent to fax information to the following numbers upon patient request: ____________________________

Messages may be left on **my voicemail** (For lab results, treatment, etc.) no___ yes ___ @ ______________________
Phone Number (please write)

Messages may be left with the following persons:

Name_____________________________ Relationship____________________ Phone________________________

Name_____________________________Relationship____________________ Phone________________________

Name_____________________________Relationship____________________ Phone________________________

Consent to release information to physicians involved in my healthcare:

Physicians name:_________________________________ Practice Name:________________________

Physicians name:_________________________________ Practice Name:________________________

Physicians name:_________________________________ Practice Name:________________________

Consent to release information to my pharmacy if asked for treatment or payment purposes:

Pharmacy Name & Phone Number:____

Diabetic Supply Company Used (Testing & Pump Supplies):____

Note: 1. By law, Lancaster Endocrinology cannot use or share my health information without my permission, except by ways listed in the Lancaster Endocrinology notice of private practices. 2. I can cancel this permission/request at any time. I must cancel in writing and will receive written confirmation from Lancaster Endocrinology of their receipt of my request. I cannot cancel the sharing of information already given as a result of this permission. 3. There may be a charge to make copies of my medical record. 4. I understand and acknowledge that this may include treatment for physical and mental health, alcohol/drug abuse and/or HIV/AIDS tests results or diagnosis. If the person signing this permission is the patient's legal guardian, healthcare agent, attorney, or administrator/executor of the patient's state appropriate documentation of legal authority must be provided before records may be released.

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Signature **Date**