RELEASE OF MEDICAL RECORDS AUTHORIZATION FORM

Lancaster Endocrinology, Dr. Robert Wozniak
410 S. Herlong Ave. Ste. 106 • Rock Hill, SC 29732
Tel: (803) 329-3899 Fax: (803) 327-3438

Please fill out sections 1-6 and sign and date at the bottom

1) Patients Name:_____ Date of Birth:_____

SS# :_____ Telephone:_____

Address: _____

2) Information to include:

____Full Disclosure of all records
____Office Visits
____Labs
____Test Reports
____Other:_____

3) Purpose of Disclosure:

____Patient Request
____Treatment
____Legal
____Other:_____

4) Date range requested _____ to _____

5) The health information described above may be used or released **to**: check

_____Lancaster Endocrinology: Fax: (803) 327-3438

OR

_____ Practice Name: _____ Physician Name: _____

Address: _____

Phone:_____ Fax:_____

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 to the address above. 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. 5. 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.

6) Please check one:

____This authorization expires on the following date:_____unless otherwise revoked by the patient.
OR
____No expiration is specified.

_____ _____ _____
Print Name Signed Name Date