

Pee Dee Pathology Associates
AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that the person or entity authorized to receive the information is not a healthcare provider, and the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

Social Security No.: _____ Date of Birth: _____

Person/entity authorized to receive the information: _____

Specific description of information (including dates): _____

The purpose of the use or disclosure is: _____

Will the person or entity requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No _____

- I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
- I understand that this authorization will expire on _____ or 1 year from the signature date or period as specified by state law, whichever date occurs first.
- I understand that I may revoke this authorization at any time by notifying Pee Dee Pathology Associates in writing. I also understand that if I revoke this authorization, the revocation will not have any effect on actions taken by Pee Dee Pathology Associates before Pee Dec Pathology Associates received the revocation. I also understand that more information regarding revocation of this authorization may be covered in Pee Dee Pathology Associates Notice of Privacy Practices.

Initials _____

*Signature of Patient or
Patient's Legal Representative*

Date

Printed Name

*Relationship of Legal Representative to
Patient*