



Strand Regional Specialty Associates LLC

FAX # 843-497-2505

(Print Patient's FULL name)

(Birth Date—Mo/Day/Yr) or (Last 4 of Social Security Number)

(Street Address)

(Home Phone)

(City) (State) (Zip Code)

At the request of the individual, I _____, do hereby voluntarily authorize Strand Regional Specialty Associates to use or disclose protected health information about me as described below. I understand the disclosed information may include information and records protected by Federal Law (such as alcohol and drug treatment) and/or State Law (such as mental health, AIDS, or HIV).

Dates of _____

(Please check all that apply)

- Discharge Summary, Pathology Reports, Progress Notes, Radiology Reports, History & Physical, Laboratory Reports, Operative Notes, ECG/EEG/Cardiac Cath, Emergency Reports, Other: _____

Information Release To:

Name of Company/Agency/Facility/Person

Street Address

(City) (State) (Zip Code)

Fax Number Attention to

Purpose of Disclosure:

(Please check all that apply)

- Referral to Specialist, Insurance, Workers Comp, Legal Investigation, Disability, Personal, Change of Doctor, Continuing Care, Other

**PLEASE PROVIDE CURRENT PHONE NUMBER IN THE EVENT WE NEED TO CONTACT YOU: _____

- I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations. I may revoke this authorization by notifying Strand Regional Specialty Associates in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that this authorization is valid for the purposes of this release only. Any further information needed will require an additional authorization.

Patient or Patient Personal Representative Signature

Date

Relationship to Patient