



Professional Pathology Services, PC

HIPAA Privacy Division

1701 Saint Julian Place

Columbia, SC 29204

Phone: (803) 252-1913 Fax: (803) 252-2330

PATIENT AUTHORIZATION FORM 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 if the person or entity authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

Social Security #: _____

Person/entity authorized to provide the information: _____

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. Yes No

I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it.
____ Initials

I understand that this authorization will expire on _____. _____ Initials

I understand that I may revoke this authorization at any time by notifying PPS (Professional Pathology Services PC) in writing. I also understand that if I revoke this authorization, the revocation will not have any effect on actions taken by PPS before PPS received the revocation. I also understand that more information regarding revocation of this authorization may be covered in Professional Pathology Services' Notice of Privacy Practices.
____ Initials

Signature of Patient or Patient's Legal Representative

Relationship of Legal Representative to Patient

Printed Name

Date