LAKESIDE ORTHOPAEDIC CENTER, LLC of Manning

50 East Hospital Street, Suite 6
Manning, SC 29102

Phone: 803-433-5633
Fax: 803-433-5636

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME _____
LAST FIRST MI MAIDEN

DATE OF BIRTH ____/____/____ SS# ____-____-____ MEDICAL RECORD # _____

_____
ADDRESS CITY STATE ZIP

DAY PHONE _____ EVENING PHONE _____

☐ I authorize *Lakeside Orthopaedic Center, LLC* to use or disclose my protected health information as indicated below to:

_____
Name of entity to receive this information

_____
ADDRESS CITY STATE ZIP

_____ _____
PHONE NUMBER FAX NUMBER

☐ I authorize _____
Name of entity to release this information

To release my protected health information to *Lakeside Orthopaedic Center, LLC* as indicated below.

INFORMATION TO BE RELEASE:	PURPOSE OF DISCLOSURE:
☐ From & To dates _____	☐ Changing Physician
☐ History and physical exam	☐ Continuing care
☐ Office notes	☐ At patient request
☐ X-ray reports	☐ Second opinion
☐ Lab reports	☐ Legal
☐ Hospital records (Op note, Discharge Summary)	☐ Insurance/Workers' Compensation
☐ Medication records	☐ School
☐ Other: _____	☐ Other: _____

I understand that this authorization will expire: _____
Expiration Date or Defined Event

I understand that I may revoke this authorization at any time by notifying *Lakeside Orthopaedic Center, LLC* in writing. This authorization will cease to be effective on the date notified except to the extent that the practice has acted in trust upon this authorization.

_____ _____
Signature of Patient or Legal Guardian Date