

WELCOME TO LANCASTER ENDOCRINOLOGY

REVISED 5/11/07

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Lancaster, SC 29729
(803) 286-9001**PATIENT INFORMATION / RELEASE OF INFORMATION**

Patient Name Last:		First:		M.I.
Home Address:		City:	State:	Zip Code:
Phone Home:		Phone Work/Cell:		Sex:
Birth Date:	Age:	Employer:	SS #:	
Spouse Name:		SS #:		Date of Birth:
Spouse Employer:		Work Phone:	Cellular phone #:	
Family Doctor(Primary Care Physician):		Phone #:	Name of Practice:	
Minor/Parent or Guardian:			Relation with Patient:	
Referring Doctor:				
In case of an emergency please call:				

I _____, authorize the release of my medical records to the physicians of Lancaster Endocrinology.

Records Needed: _____

Consent to Release Medical Information to Family

It is frequently necessary for personnel at this practice to communicate lab results, radiology results, instructions, information about treatment, and other items of Protected Health information with our patients. It is frequently not possible to speak personally or face to face with the patient. In the event that our staff is not able to speak with you (the patient) directly, please give us instructions about communicating with you.

Messages may be left with the following persons:

Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

Messages may be left on voicemail @ _____

Patient co-payments and patient portions are due at the time of service. Patient balances from statements are due within 30 days of receipt. For insurance billing: I hereby authorize Lancaster Endocrinology to furnish my insurance company all information requested concerning my present illness or injury. I hereby authorize payment of insurance benefits to Lancaster Endocrinology and I am personally responsible for non-covered services and items. I am aware that account balances over 90 days late are subject to a late fee and/or collection agency fee. I hereby authorize Lancaster Endocrinology to send and receive insurance information necessary for claim submission and resolution. I hereby authorize Lancaster Endocrinology to release any information acquired in the course of my examination to my physician. I have received and read a copy of Lancaster Endocrinology's Privacy Act.

Signature

Date