Patient Authorization for Release of Medical Records

This form allows you to send records to the Charleston Thyroid Center.

Patient Name: _____ Date of Birth: _____/_____/_____

I hereby authorize the person / company listed below to release my protected health information in the manner listed below, and to the following:

Released From:

Company and/or Doctor's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Email: _____

Send By: (choose ONE) ☐ **Fax** ☐ **Secure Email** ☐ **Mail**

Send To:

Charleston Thyroid Center, LLC
1054 Johnnie Dodds Blvd., Suite A
Mount Pleasant, SC 29464
Phone: (843) 388-7545
***Fax:* (843) 388-5548**
Secure Email: office@charlestonthyroid.com

Please Send:

☐ **All Records**

or

☐ **Specific Items Only** (please list): _____

In general, we need at least the last 2-3 years of thyroid-related records (office notes, labs, ultrasound reports, surgical & pathology notes, operative reports, etc.)

_____ _____ _____/_____/_____

Signature of Patient/Guardian/ Power of Attorney/Healthcare Surrogate | Relationship to Patient | Date

Charleston
THYROID CENTER