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AUTHORIZATION FORM TO RELEASE MEDICAL INFORMATION

Patient Name _____
Date of Birth _____
Social Security _____

I, _____ hereby authorize **The Endocrine Center, (Denise Armellini M.D)** to use and disclose Protected Health Information (PHI) to:

Name of Provider or Organization _____
Address _____
Phone number _____

Information to be disclosed, check all that apply:

Medical Records (chart notes) Diagnostic Records (Ultrasound, labs) Other _____

This protected health information is being used or disclosed for the following purposes:

- Share medical information with other healthcare providers
- Personal use
- Transferring care to a new healthcare provider
- Legal investigation
- Other: _____

Patient Rights

I understand that I have the right to revoke this authorization at any time by notifying The Endocrine Center, P.C. in writing. I also understand that I can refuse to sign this authorization form and that my refusal will not affect my ability to obtain healthcare benefits (treatment, payment or my eligibility for benefits if applicable). I may inspect or copy any information used or disclosed under this agreement. I understand that if a person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations. To view the process for revoking this authorization, please read the privacy notice to patients posted at the office.

Signature of Patient/Patient's representative

Date

Printed name of person signing above