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AUTHORIZATION FORM TO RELEASE MEDICAL INFORMATION

Patient Name _____
Date of Birth _____
Social Security _____

I, _____ hereby authorize **The Endocrine Center,** 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
☐ Disability
☐ Transferring care to a new healthcare provider
☐ Attorney
☐ At the patient request, for their personal records
☐ Other: _____

Patient Rights

I understand that I have the right to revoke this authorization at any time by notifying The Endocrine Center 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