diabetes & endocrine associates

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

PRINT NAME OF PATIENT _____ DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

Information to be released from:

NAME OF DESIGNATED FACILITY AND/OR PROVIDER _____

ADDRESS _____

CITY, STATE, ZIP CODE _____ PHONE NUMBER _____

Information to be sent to: **(Please Circle one)** **Dr. Paul Abram Graham** **Dr. Denise Tonner** **Dr. William Lasswell**

DIABETES & ENDOCRINE ASSOCIATES
2835 20th STREET, BUILDING C
VERO BEACH, FL 32960 Tel: (772) 299-3003 Fax: (772) 299-3005

Information to be released:

- All medical records from date of initial evaluation and treatment, to the date you receive this authorization. **(Chart notes, billing records, labs, x-rays, etc.)**
- The _____ most recent years of pertinent information. **(Chart notes, billing records, labs, x-rays, etc.)**
- Other Specific information **(**Specific **dates of treatment, date range, etc.): _____**

Purpose for which disclosure is being made:

Attorney/Legal Insurance Doctor Personal Other: _____

Protected Records:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for all of these records to be released. **(Excluding psychotherapy notes)**

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing at any time. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. I understand that Diabetes & Endocrine Associates may not condition my treatment on my refusal to sign this authorization, except for research-related treatment or when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party on provision of an authorization for the disclosure of the protected health information to such third party.

This authorization will expire (complete one):

☐ On _____/_____/_____

☐ On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized):

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

*** Parent or Guardian may sign ONLY if patient is 14 yrs or younger. If signed by authorized representative, attach appropriate legal documentation.**