Endo Care of South Florida
Center for Endocrine and Diabetes Care

Authorization for Release of Health Information

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company or health care provider, the released information may no longer be protected by federal privacy regulations.

PURPOSE OF RELEASE: ❑ Ongoing Communication ❑ Copy of Record ❑ Legal or Insurance Review ❑ Authorized Representative's Request
❑ Other _____

RELEASE FROM: The facility/practice/individual listed below is authorized to release the requested health information:

Facility/Practice Name: _____ Telephone #: _____

Facility/Practice Address: _____ Fax #: _____

The facility/practice/individual listed above is authorized to release the requested health information for the following: date(s) of service, range of time or event(s): From: (MM/DD/YY) _____ To: (MM/DD/YY) _____

CHECK THE SPECIFIC INFORMATION TO BE RELEASED:

❑ All Records & Details
❑ Appointment Information
❑ Billing Information
❑ Consultation Report
❑ Discharge Summary
❑ Emergency Room Records
❑ History & Physical
❑ Immunization Records
❑ Lab/Pathology Reports
❑ Medication Records
❑ Office/Clinic Notes
❑ Operative Report
❑ Physician's Orders
❑ Progress Notes
❑ Psychiatric Evaluation
❑ Radiology/Imaging Reports
❑ Test Results
❑ Other (Please Specify) _____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

NAME OF PATIENT WHOSE INFORMATION IS TO BE RELEASED:

Patient Name: _____ (First) _____ (Middle/Maiden) _____ (Last)

Patient Address: _____ (Street Address/PO Box, City, State, Zip)

Social Security #: _____ Date of Birth: _____ Medical Record/Chart # _____

Please provide phone numbers where you are authorizing CHS to leave patient information as described above:

Home: _____ Work: _____ Cell: _____

RELEASE TO: This information may be released to and used by the following individuals/organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals/organizations listed below:

Name	Address	Telephone/Fax #	Relationship

PATIENT'S RIGHTS AND SIGNATURE:

- I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the above named organization in writing. (I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.)
- I understand that authorizing the disclosure of this private health information is voluntary and I can refuse to sign this authorization.
- I understand that I may request to obtain a copy of the information to be used or disclosed per CHS' Notice of Privacy Practices/Policy.
- This authorization will expire when the information from the event/purpose noted above is released to the recipient named in this document.

If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization.

PRINT NAME (Patient/Authorized Representative): _____

SIGNATURE: _____ DATE: _____

If Authorized Representative, please indicate relationship to patient: ❑ Spouse ❑ Parent ❑ Guardian ❑ Executor of Estate ❑ Power of Attorney

For Endo Care of South Florida Use Only: ECSF Employees Please complete:

❑ Identification verified ❑ Copy of Authorization given to patient Date of release: _____ via ❑ Mail ❑ Fax ❑ Other _____

❑ Accepted - Released information as described above ❑ Partially Accepted - Describe patient information not released: _____

_____

Employee Name & Title _____

Employee Signature: _____ Date: _____