NORTHEAST
ENDOCRINOLOGY
ASSOCIATES P.A.

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Authorization for release of Health Information

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name: ____ **Date of Birth:** ____ / ____ / ____

SSN (optional): _____________ - _____________ - _________________

I authorize the following individual(s) or organization(s) to disclose the above named individual's health information:

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For the purpose of **MEDICAL TREATMENT**, please release the following records:

- ☐ **All Records**
- ☐ **Lab Results (indicate)**____
- ☐ **Bone Mineral Density Report**
- ☐ **Other (indicate)**____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I hereby consent to the release of any and all records listed above. This authorization is valid for six months from the date of my signature. I understand that I have the right to revoke this authorization at any time.

If the patient is a minor and/or unable to give consent, the authorization must be signed by the legal representative or guardian. I understand the contents of this form as represented by my signature.

Signature of Patient or Legal Representative: ____

Relationship to the Patient (if Legal Representative): ____

Today's Date: ____ / ____ / ____