



NORTHEAST
ENDOCRINOLOGY
ASSOCIATES P.A.

Dr. Laura S. Akright * Dr. Arthur Guerrero
Dr. Omar Najera * Jeremy Schmidt FNP, CDE
5000 Schertz Parkway #200 • Schertz, Texas 78154
210.650.3360 (office) • 210.650-3403 (fax)
www.neendocrinology.com

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:

.....

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: ____ / ____ / ____