

 **7323 North Loop 1604 East, suite 601 San Antonio, Texas 78233**

 **Ph# (210)650-3360 Fax# (210)650-3403** **info@neendocrinology.com**

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Please indicate other names used)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City State Zip

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Northeast Endocrinology (to) (Please Select): \_\_\_\_release my record \_\_\_\_ receive my record (from):

Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City State Zip

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Northeast Endocrinology to release health and financial information on my behalf to the following person(s):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE CHECK INFORMATION TO BE RELEASED:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Complete Health Records** |  | Operative Reports |  |
|  | Financial Details |  | Laboratory Reports |  |
|  | Pathology Reports |  | X-Ray Reports |  |

 COVERING PERIOD: FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Time Limit & Right to Revoke Authorization

Expect to extent that action has already been taken in reliance on this authorization, at any time I

can revoke this authorization by submitting a notice in writing to the facility **of Northeast Endocrinology,**

**A Division of Synergy**. Unless revoked, this authorization will expire **365 days** from date of signature.

 **Drug and/or Alcohol, and/or Psychiatric, and/or STD/HIV/AIDS Records Released**

### **Re-disclosure**

I understand the infor-

mation disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and

Accountability Act of 1996. The facility, its

employees, officers and physicians are hereby released from any legal responsibility or liability

for disclosure of the

above information to the

extent indicated and

authorized herein.

 I understand that the requested information may contain reference to or results of HIV/AIDS (Human

 Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, drug and/or alcohol

 abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information.

 I authorize the release of such confidential information to the indicated party, unless prohibited in my instructions above.

 **Signature of Patient or Personal Representative Who May Request Disclosure**

 I understand that I do not have to sign this authorization, and my treatment or payment for services will

 not be denied if I do not sign this form. I have received a copy of the protected health information to be used or disclosed.

 I authorize Northeast Endocrinology to use and disclose the protected health information specified above.

 **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Authority of Sign if not patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Witness:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_