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
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: ______________________________

Re-disclosure
I understand the information 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.