Alliance Endocrinology

Authorization to Release Medical Records

I,_____ DOB:_____
(Name of Patient Last, First, MI)

Here by authorize the following provider to release my records
FROM:_____
(Name, Address, Phone/Fax of Provider **RELEASING** record)

TO: _____
(Name of person/entity who should entity who is **RECEIVING** records)

Address:
_____

City, State, Zip Code:
_____

Phone Number: _____Fax Number: _____

For the purpose of: _____
My authorization extends only to those data elements/documents marked below:

___ All Health Information
___ Statements/Charges/Payments
___ Hepatitis Information
___ AIDS or HIV Information: initials ____
___ Substance Abuse Records: initials ____
___ Genetic Information: initials ____
___ Record of visit for specific date(s): (Include date range to be release)
___ Other (please specify below)
_____

I hereby authorize this release of information and understand that:

- Any and all records are confidential and cannot be disclosed in any form without my prior written authorization, except at provided by law.
- A photocopy or fax of this authorization is valid same as original.
- I may revoke this authorization at any time in writing except where information has already been released.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
- Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining this authorization.

_____ Date: _____
Patient/Legal Representative Signature

_____ _____
Relationship to Patient Expiration Date of Authorization

_____ Date: _____
Witness Signature