DIABETES & THYROID CARE

AUTHORIZATION TO REQUEST PATIENT HEALTH INFORMATION FROM OUTSIDE HEALTHCARE PROVIDERS:

Patient Name _____

DOB ____ /____/_____ SSN: __ __ __ - __ __ - __ __ __ __

I, _____ hereby authorize the release of the following records from:

Name of Provider or Organization _____

Address _____

Phone number _____

Information to be disclosed (check all that apply):

□ Medical Records (chart notes) □ Diagnostic Records (Ultrasound, labs) □ Hospital discharge

□ Pathology □ Others _____

This protected health information is being used or disclosed for the following purposes:

□ Transferring care to a new healthcare provider □ Continuity of care

Patient Rights

I understand that I have the right to revoke this authorization at any time by notifying Diabetes & Thyroid Care, LLC . in writing. I also understand that I can refuse to sign this authorization form and that my refusal will not affect my ability to obtain healthcare benefits (treatment, payment or my eligibility for benefits if applicable). I may inspect or copy any information used or disclosed under this agreement. I understand that if a person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations. To view the process for revoking this authorization, please read the privacy notice to patients posted at the office.

_____ _____

Signature of Patient/Patient's representative **Date**

_____

Printed name of person signing above

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