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Authorization for *Florida Diabetes Thyroid and Endocrine Center* to release protected health information

Patient's name: _____ DOB: _____
Social Security number_____ Phone number_____
I hereby authorize *Florida Diabetes Thyroid and Endocrine Center* to RELEASE my protected health information to the following organization(s) and/or person(s).
Doctor or facility name_____
(Required)
Address:_____
Phone_____ Fax_____
(Required) (Required)
I authorize the following information to be released:
All lab work, radiology reports, consultation reports from the last 3 years, last 3 office notes:
_____
(Specify other records needed when applicable)
Purpose of requested disclosure: Please initial one
_____ At the request of the patient
_____ Other (Continuing care of the patient)
I understand I have the right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the Privacy officer. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my PHI and have acted in reliance upon this authorization. I understand I do not have to sign this authorization and that *Florida Diabetes Thyroid and Endocrine Center* may not condition treatment on whether I sign this authorization. I further understand that if the person(s) or organization(s) authorized to receive this information is not a health plan or healthcare provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this authorization or fax of this release shall be valid as the original release. If I authorize *Florida Diabetes Thyroid and Endocrine Center* to fax information, I realize there are inherent risks in faxing protected health information, I understand a fee will be charged to cover costs of copying, including costs of supplies and labor of copying and mailing protected health information released to anyone other than another health care provider. I understand I may receive a copy of this form after I sign it.

_____ _____
Signature of patient/guardian Date

_____ _____
Printed name of patient Relationship to patient