Firehouse Diabetes and Endocrine Center – RECORDS RELEASE FORM

Authorization for Use and Disclosure of Protected Health Information

Last name	First	MI	DOB

Primary Phone Number Home Cell	Cell Phone Number	Work Number

Reason for Request: Personal Medical Care Benefits Worker's Comp Transfer of care to New Provider Other

I AUTHORIZE INFORMATION RELEASE ***FROM***	INFORMATION TO BE RELEASED ***TO***
______________________________ **Name of Facility/Provider**	______________________________ **Name of Facility/Provider**
______________________________ **Address**	______________________________ **Address**
______________________________ **City, State, Zip**	______________________________ **City, State, Zip**

I understand that Firehouse Diabetes and Endocrine Center may not condition my treatment on whether I sign this authorization form unless specified above under Reason for Request. I can inspect or copy the protected health information to be used or disclosed. Except to the extent that action has already been taken in reliance on the authorization, at any time I can revoke this authorization by submitting a notice in writing to the facility Privacy Officer at Firehouse Diabetes and Endocrine Center. Unless revoked, this authorization will expire in 180 days or on the following date or event ______________________________.

I authorize Firehouse Diabetes and Endocrine Center to use and disclose the protected health information specified below.

______________________________ ______________________________
Signature of Patient or Patient's Legal Representative DATE

______________________________ ______________________________
PRINT Patient's Name or Name of Legal Representative Relationship to Patient

Type of Information to be Released

Specific Information Only Please

- ☐ Chart Notes
- ☐ Laboratory Results
- ☐ X-Ray Reports/Films
- ☐ Emergency Room Report
- ☐ Immunization Records
- ☐ Medication Records
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Other ____________________
- ____________________
- ____________________

☐ Most Recent Visit ☐ Medical Records from __________ to __________ ☐ Last 2 years

Note: If checkbox if not selected, the last 6 months will be copied/printed. **There may be fees for providing copies.**

Protected or Sensitive Information

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV / AIDS information
Initials

_____Mental Health Information
Initials

_____ Drug / Alcohol diagnosis, treatment or referral information
initials

_____ Genetic Testing Information
Initials

I understand that the information used or disclosed pursuant to the authorization may be subject to re-disclosure and no longer protected under federal law; however, I also understand that federal law or state law may restrict re-disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral.

2.21.2019 jpd