

# AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION



www.endoclinic.net

## Patient Information

Patient Name	First	Middle Initial	Last		
Birth Date	/	/	Social Security #		
Home Address	Street	Apt. #	City	State	Zip Code
Home Phone ( )	Work Phone ( )	Ext.	Pager/Cell Phone		

## Request for health information

**This authorization is for the following information** (check those that apply and indicate the needed date(s) of service)

<input type="checkbox"/> Office Notes	<input type="checkbox"/> Laboratory Reports	Date(s) of Service to be Used/Disclosed:
<input type="checkbox"/> Diagnostic Tests	<input type="checkbox"/> Radiology Reports	___/___/___ to ___/___/___
<input type="checkbox"/> Other: _____		Other: _____

**The Endocrinology Clinic of Minneapolis is authorized to:**

(Circle One) SEND / RECEIVE the above information.

**The Exchange will occur with the following person or group:**

Person/Group: \_\_\_\_\_ Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

**The Purpose for this request is:**

(Circle One) Medical Care / Legal / Insurance / Research / Other : \_\_\_\_\_

## Authorization

I authorize the Endocrinology Clinic of Minneapolis to use or disclose the protected health information of the individual listed below as indicated. Incomplete or invalid requests will be returned to the proper individual.

I understand that sensitive information including information regarding HIV/AIDS, alcohol and drug abuse and/or mental health treatment may be released as part of this disclosure unless I initial here and indicate what sensitive information I do not want disclosed. Initials: \_\_\_\_\_ Information Not to Be Disclosed: \_\_\_\_\_

I understand that signing this authorization is not required in order for me to receive treatment except as indicated in any privacy practices notices I have received. I understand that I can revoke this authorization in writing by sending notice to the facility releasing the above information. I understand that once information is disclosed, it may no longer be protected by federal or state privacy rules and therefore may be re-disclosed by the recipient of the information without protections.

I understand that the Endocrinology Clinic of Minneapolis may use a copy service to process the request for medical records and that there may be a fee for obtaining these records.

Unless otherwise indicated here this authorization shall expire in one year. Other Expiration Date: \_\_\_\_\_

I understand the terms of this form and authorize the disclosure/use as indicated above.

\_\_\_\_\_  
Patient (or Patient Representative) Signature Date

If signed by Patient Representative, state authority to do so and attach documentation to verify this fact:

\_\_\_\_\_  
Witness Signature Date