Endocrinology & Metabolism of east alabama

**AUTHORIZED PATIENT**
**NOTIFICATION LIST**
**(**Required of HIPAA) Health Insurance Portability and Accountability

I authorize all Endocrinology and Metabolism of East AL and/or whomsoever he/she may designate as his/her professional representative/assistant to discuss any aspect of my primary care, to include: appointments, tests, test results, surgical procedures, prescriptions, and any other pertinent information pertaining to my care with the following designated people (ie. Spouse, child, friend):

This document will be a part of your permanent record. In the event that any of the selected representatives that you have designated change, it will be necessary to update our records with a written notification. You will need to state who you would like to have removed from or added to the Authorized Notification List.

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|---|---|
| PATIENT/OTHER PERSON AUTHORIZED TO SIGN | DATE |
| RELATION TO ABOVE SIGNATURE | DATE |
| WITNESS SIGNATURE | DATE |