

# Endocrinology & Metabolism

of east alabama

2420 Village Professional Drive, Opelika, AL 36801 334-528-7270 fax 334-528-7271

Dr. Neil Schaffner, MD

## AUTHORIZATION TO DISCLOSE / RELEASE OR OBTAIN MEDICAL RECORDS

All disclosures are in compliance with federal and state laws, including the Health Insurance Portability and Accountability Act of 1995 (HIPAA), governing the use and disclosure of Protected Health Information (PHI)

Pt Name \_\_\_\_\_ DOB \_\_\_\_\_

Address/ Phone \_\_\_\_\_

*I hereby authorize Endocrinology and Metabolism to:*

\_\_\_\_\_ **Disclose/ Release to**

\_\_\_\_\_ **Obtain From**

\_\_\_\_\_  
Name of Person or Organization

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
Fax

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

**INFORMATION REQUESTED:** I hereby agree to this authorization and understand that it must contain personally identifiable information and PHI as defined by HIPAA to ensure accuracy. I understand I have the right to limit the type of information released and to revoke this authorization by submitting a notice, in writing to the Privacy Officer. Unless revoked, this authorization will expire three months for date of signature or on the following date: \_\_\_\_\_

If I choose to limit the information released, I understand Endo and Metabolism may inform the requestor that portions of the record have been withheld. I understand the information disclosed may be subject to re-disclosure by the recipient and no longer be protected by Endo and Metabolism. Endo and Metabolism and its staff are hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized.

\_\_\_\_\_ PARTIAL medical records; please specify parts and dates to be released: \_\_\_\_\_

\_\_\_\_ Progress Notes

\_\_\_\_ Immunizations

\_\_\_\_ Xray Reports

\_\_\_\_ Allergy

\_\_\_\_ Lab Report

\_\_\_\_ Physical

\_\_\_\_ GYN Report

\_\_\_\_ Consultation

\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_ ALL medical records without exception; including all lab testing (HIV) and mental health treatment.

**For the purpose of:** \_\_\_\_\_

*I authorize the release of my medical records as indicated above.*

\_\_\_\_\_  
**Pt Signature**

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

*Note to recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal and State Laws (including HIPAA) and prohibits you from further disclosure without written consent of the person to whom it pertains. Charges may apply for copies of medical records.*

\_\_\_\_\_ Faxed

\_\_\_\_\_ Copies Left for pt

\_\_\_\_\_ Mailed

Date \_\_\_\_\_