RALEIGH ENDOCRINE ASSOCIATES

2709 Blue Ridge Road, Suite 320, Raleigh, North Carolina 27607 • Phone (919) 876-7692 • Fax (919) 954-3365

Authorization to Release and/or Request Medical Records

I authorize Raleigh Endocrine Associates **to use or disclose to**:

Name of Person or Facility: _____

Street Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Email: _____

The Protected Health Information of:

Patient Name: _____ SS# (Last 4 digits): _____

Date of Birth (mm/dd/yyyy): _____ Phone Number: _____

Street Address: _____ City, State, Zip: _____

Date of Service (Specify Date or Date Range): _____

☐Office Visit Notes ☐History and Physical ☐Labs/Pathology ☐Thyroid Ultrasound ☐Bone Mass Density

☐ Medication List ☐ Physician orders ☐Patient Billing Records ☐Other_____

Purpose of Request:

☐Personal Use ☐Continued Patient Care ☐Attorney / Legal ☐Insurance ☐Social Services / Disability ☐Other_____

I UNDERSTAND THAT:

- I may revoke this Authorization at any time:
  - The revocation will not apply to information that has already been released in response to this Authorization.
  - I must revoke this Authorization in writing. The procedure for revoking this Authorization is to present my written revocation to the Front Office staff.
- I may refuse to sign this Authorization:
  - My treatment, payment, enrollment in a health plan, or eligibility for benefits can not be conditioned upon my authorization of this disclosure.
  - A fee may be charged for providing the protected health information. Please contact our office to obtain fee and rate information.

I understand that the information released may include sensitive information related to behavior and/or mental health, drugs and alcohol, HIV/AIDS and other communicable diseases, and genetic testing.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date or event or condition, this authorization will expire automatically in **one (1) year** from the date of signature.

I have read and understand the information in this Authorization form.

_____ _____

Print Name of Patient or Authorized Representative **Relationship to Patient**

_____ _____

Signature of Patient or Authorized Representative **Date and Time**