Authorization for Use and Disclosure of Protected Health Information

I authorize **THE ENDOCRINOLOGY CLINIC OF MINNEAPOLIS (952-927-7810)** to use or disclose the protected health information of the individual named below as indicated. Incomplete or invalid requests will be returned to the proper individual.

Patient Name	Previous Patient Name	Date of Birth
Street Address	Apt or Suite	City
State	Zip Code	Phone

This authorization is for the following information (check those that apply and indicate the needed date(s) of service: [Two years of records will be sent if date of service is left blank.]

Date(s) of Service to be Used/Disclosed: ____/____/_____ to ___/___/_____ ____

Diagnostic Tests ____ Lab Reports ____ Radiology Reports ____ Office Notes

Other: _____

Do you have an upcoming appointment? Please supply date of appointment: _____

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.

THE ENDOCRINOLOGY CLINIC OF MINNEAPOLIS is authorized to: **(Circle One) SEND/RECEIVE** the above information.

This exchange will occur with the following person or group:_____
Person/Group

_____ _____
Address City/State/Zip

Phone # _____ Fax # _____

The purpose for this request is: Circle one: Medical Care – Legal – Insurance – Research – Other:_____

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.

Unless otherwise indicated here this authorization shall expire in one year. Other Expiration Date: _____
I understand I have the right to revoke the authorization, in writing, at any time. 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: _____