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AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT'S NAME:_____ **DOB:**_____

ADDRESS:_____ **PHONE:**_____

I hereby authorize the use of disclosure of my individually identifiable information described below.

Obtain the medical records from: _____

_____

Send the medical records to: _____

_____

Please release the following information:
Covering the period of health Care from: Date_____ **to Date:**_____
ENTIRE MEDICAL RECORD_____
Specific information dates_____
OFFICE NOTES _____ **LABS** _____ **X-RAYS**_____

NOTE: There is a 75 cent charge PER PAGE COPIED as allowed by law, if this record is NOT being sent to a physician or another facility for continuity of care. The information being used or disclosed pursuant to this authorization may be subject to redisclosure, and may no longer be protected by the privacy law.

PURPOSE OR NEED FOR THIS REQUEST (Check one):
Transferring records_____ **Consult with another physician**_____
Other (please specify)_____
This authorization will remain in effect for:
One year _____ **90 days**_____**, unless I specify an earlier date here:**_____

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been take in reliance on this authorization and if this authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer with the right to contest the claim under the policy or to contest the policy itself. To revoke this release from Primary Care Metabolic Disorders Medical Practice, PLLC, provide a signed statement in writing to the above address. Unless otherwise revoked, this authorization will expire on the date, event or condition above. Primary Care Metabolic Disorders Medical Practice,PLLC is released from all legal responsibilities, which may occur from the release of requested information.
I understand Primary Care Metabolic Disorders Medical Practice, PLLC will not condition my treatment on whether I provide authorization for the requested use or disclosure if to do so would be prohibited by federal or state law. If a reason exists under law for conditioning my treatment on obtaining this authorization, I have been advised of the fact and the consequences to me refusing to sign this authorization. (If authorization is being requested for marketing purposes, *including the following if applicable: The use or disclosure requested under this authorization is expected to result in* direct or indirect remuneration to Primary Care Metabolic Disorders Medical Practice, PLLC from a third party).

Patient Signature:_____ **Date:**_____

_____

Legal Representation Signature **Relationship to Patient** **Date**