ARKA
ENDOCRINE CLINIC

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Authorization to Release Medical Records

I, ____ (Name of Patient Last, First, MI)

Date of Birth: ____________________ SSN: ____________________

Here by AUTHORIZE THE FOLLOWING TO DISCLOSE MY PROTECTED HEALTH INFORMATION:

Person/Organization Name ____

Address ____ City ______________________________________

State __________ Zip Code ________________ Phone (_______)___________________Fax (_______)________________________________

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION ?

Person/Organization Name ____

Address ____ City ______________________________________

State __________ Zip Code _________________ Phone (_______)___________________Fax (_______)________________________________

Reason for disclosure (choose one option)-

	Treatment/Continuing Medical Care		Personal Use		Billing or Claims		Insurance
	Legal Purposes		Disability Determination		School		Employment/other

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. If all health information is to be released, then check only the first box.

	All health information		History/Physical Exam		Past/Present Medications		Lab Results
	Physician's Orders		Patient Allergies		Operation Reports		Consultation Reports
	Progress Notes		Discharge Summary		Diagnostic Test Reports		EKG/Cardiology Reports
	Pathology Reports		Billing Information		Radiology Reports & Images		Other

Your initials are required to release the following information:
______Mental Health Records (excluding psychotherapy notes) ______Genetic Information (including Genetic Test Results)
______Drug, Alcohol, or Substance Abuse Records ______ HIV/AIDS Test Results/Treatment

I hereby authorize this release of information and understand that:
- Any and all records are confidential and cannot be disclosed in any form without my prior written authorization, except at provided by law.
- A photocopy or fax of this authorization is valid same as original.
- I may revoke this authorization at any time in writing except where information has already been released.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
- Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining this authorization.

____ Date: ___________________________
Patient/Legal Representative Signature

____ ________________________________
Relationship to Patient Expiration Date of Authorization

____ Date: ___________________________
Witness Signature