Authorization for Release of Medical Information

Patient Name: _____ DOB: ____/____/_____

I, _____ hereby authorize:

Monarch Endocrinology, PLLC
146 Hazard Ave STE 107
Enfield, CT 06082
Phone: 860-386-5167
Fax: 860-962-4005

____ to RELEASE information from my medical record TO: _____to OBTAIN information FROM:

(Doctor/Clinic/Hospital): _____

Address: _____

Telephone: _____ Fax : _____

Please release the following:

___ **All health information**

___ History/Physical Exam
___ Progress Notes
___ Discharge Summary
___ Consultation Reports
___Other (specify): _____

___ Diagnostic Test Reports
___ Radiology/Images
___ Lab Results
___ Pathology Reports

I consent to the release of information related to sexually transmitted disease, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), behavioral or mental services, treatment for alcohol and/or drug abuse, and reproductive health care services treatment, with the rest of the medical records.

___ Yes, I consent to the release of this information.
___ No, I do not consent to the release of this information.

Purpose of disclosure:

___ Treatment/ Continuing medical care
___ At patient's request
___ Other _____

I understand that I may revoke this authorization at any time by providing written notice to the provider releasing the information. If I choose to do so, my revocation will not affect any actions taken before receiving my revocation. This authorization shall remain valid until such time as it is revoked in writing.

I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient(s) and may no longer be protected by HIPAA Privacy regulations. I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Signature: _____ Date: ____/____/____

Print Name: _____ Relationship to Patient: _____