AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

FROM ACE ENDOCRINOLOGY ASSOCIATES PC TO OUTSIDE PHYSICIANS

PATIENT NAME: _____

D.O.B: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

CONTACT: Home: _____ Cell: _____Email: _____

I hereby authorize **ACE ENDOCRINOLOGY ASSOCIATES PC** To disclose my health information to:

Dr./ Mr. / Mrs. _____

Phone: _____ Fax: _____

The information to be disclosed to and used by the above is for: Continuation of care / Medicolegal purposes

This authorization is limited to the following dates of treatment:

FROM _____ TO _____

Information to be disclosed:

□ LAST CONSULTATION □ LABS, X-RAYS & IMAGING

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV information, AND email correspondence as applicable. It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above. I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Dr. Smita Kargutkar of ACE Endocrinology Associates PC. I understand that this revocation will not apply to the extent of any actions that the practice has already acted in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrently with the following event or Condition: _____.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment, payment, enrollment, or eligibility for benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

If I have questions about disclosure of my health information, I can contact Dr. Smita Kargutkar, MD of ACE Endocrinology Associates PC of at 225 Highway 35 N Suite 102-B Red Bank NJ 07701 Phone: 732-413-8000.

PATIENT SIGNATURE: _____ DATE: _____

LEGAL REPRESENTATIVE: Name: _____ RELATION: _____ DATE: _____