Endocrine & Thyroid Center

7141 Colleyville Blvd, Colleyville, TX 76034, Phone: (817) 410-9993 Fax: (817) 410-9963

Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City/State: _____ Zip: _____

*I authorize the use or disclosure of the above named individual's health information as described below to be **released***

FROM:

Name: _____

Address: _____

City/State: _____ Zip: _____

Phone:_____ **Fax: _____**

To: Endocrine & Thyroid Center (Formerly Endocrinology & Reproductive Medicine of Tarrant County)

- The information to be used or disclosed is as follows: (include dates where appropriate).

  _____ Complete health records
  _____ Lab results
  _____ Physical exam
  _____ X-ray reports
  _____ Immunization record
  _____ Consultation reports
  _____ Other (please specify: _____

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I am authorizing the use or disclosure of my information for the purpose of: _____

- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ .

If I fail to specify an expiration date, event or condition, this authorization will expire in sixty days. 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 in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that 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: Karen Cohen, Privacy Officer for Endocrine & Thyroid Center.

_____ _____

Signature of patient or legal representative Date