AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization may be used to permit Diabetes and Endocrine Wellness Center, LLC to use or disclose a patient's Protected Health Information (PHI), as such term is defined by HIPAA and applicable Alabama Law. Patients completing this form should read the form in its entirety before signing, and complete all the sections that apply to their decisions relating to the use or disclosure of their PHI.

Patient Information:

Full Name (Legal): _____ Last 4 Digits of Social Security No.: _____

Other Name(s) Used: _____Date of Birth: _____ Phone: _____

Authorization to Release:

Provider/Healthcare Entity or Individual Authorized to **send or give verbal** Information:

Physician/Individual Name: _____ Practice/Company Name: _____

Address: _____City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Fax: (_____) _____

Healthcare Provider/Healthcare Entity Authorized to **receive** and use this Information:

Physician/Individual Name: _____ Practice/Company Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: (_____) _____ Fax: (_____) _____

Specific Information to be Disclosed:

□ Medical Record: From (insert date) _____ To (insert date) _____

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.

□ Other: _____

Include: (Indicate by Initialing) _____ Drug, Alcohol or Substance Abuse Records _____ Mental Health Records
_____ HIV/AIDS-Related Information _____ Genetic Information

1. **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

2. **Effective Time Period:** This authorization shall be in effect for two (2) years.

3. **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand this must be done in writing.

4. **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

5. **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____ _____
Patient/Guardian Signature Relationship to Patient Date

_____ _____
Witness Signature Date