Authorization for Release of Information

Name of Patient:____ **Date of Birth:**________________

Wilmington Endocrinology, PA is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Please Check the Following:

Entity to Receive Information: Check each person/entity that you approve to receive information	Description of Information to be Released: Check each that can be given to person/entity on the left in the same section.
☐ **Voice Mail** ☐ Home ☐ Cell	☐ Results of lab tests/x-rays ☐ Other: ____
☐ **Spouse** Name: ____________________________________ Phone Number:__________________________ ☐ **Other person(s)** Name: ____________________________________ Phone Number:__________________________	☐ Financial ☐ Medical ☐ Financial ☐ Medical
☐ **Email communication-Provide email address*** ____ *For email communication to occur, please accept the disclosure below:	☐ Medical Communication such as: Thyroid Research Medical Articles, Publication Notifications, Holiday Greetings, Newsletters ☐ Results of lab tests/x-rays, upon request
For **email and/or text communication** I understand that if information is **NOT** sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected. **X**_______________________________________ Signature Authorizing Email Communication	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

X____ ___________________________

Signature of Patient or Personal Representative Date

____

Description of Personal Representative's Authority
(attach necessary documentation)

Revised August 2017