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GRACE ENDOCRINE SERVICES
Your Health Is Our Priority!

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

I voluntarily consent to an authorize my health care provider Dr. _____ (insert name) to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: _____

Address: _____

Purpose: I authorize the release of my health information for the following specific purpose:

_____

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ All my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]
- ❑ Only the following records or types of health information:

Term: I understand that this Authorization will remain in effect:

- ❑ From the date of this Authorization until the _____ day of _____, 20___.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs: _____

Re-disclosure: I understand that my health care provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Grace Endocrine Service PLLC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the Grace Endocrine Services PLLC. Office of Compliance at the address listed above. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Patient Signature _____ **Date** _____

If Individual is unable to sign this Authorization, please complete the information below

_____ _____ _____ _____

Name of Guardian/ Representative **Legal Relationship** **Date**

_____