Diabetes & Endocrinology Specialists, Inc.

222 S. Woods Mill Road
Suite 410 North
Chesterfield, MO 63017
Office: (314) 469-6224
Exchange: (314) 364-5296
Fax: (314) 469-0744

Norman Fishman, M.D.
Rachel Fishman Oiknine, M.D.
Ralph Oiknine, M.D.

Board Certified in Internal Medicine
Board Certified in Endocrinology

Authorization to Release Medical Information

Patient Name: _____ Former Name (if any): _____
PLEASE PRINT

Current Address: _____ D.O.B: _____
P.O. BOX STREET CITY STATE ZIP

Daytime Phone: _____ Evening Phone: _____ S.S #: _____

I AUTHORIZE INFORMATION RELEASED **FROM**:

_____
Name of Facility

_____
Name of Physician

_____
Address

_____
City, State, Zip

I AUTHORIZE INFORMATION RELEASED **TO**:

Diabetes & Endocrinology Specialists, Inc.
Facility To Receive Information

_____
Title (Physician, Healthcare Facility, etc.)

222 S. Woods Mill Road, Suite #410N
Address

Chesterfield, MO 63017
City, State, Zip

Purpose of Release (Please Check):
❑ Changing Primary Care Physician/Clinic ❑Referral/Consultations ❑Insurance ❑Legal ❑Self/Other

Type of Information to be Released

❑ **GENERAL Medical Records** – excluding protected records: (Copies of medical records will be limited to two years of information including lab, X-ray unless otherwise requested.)

❑ **Specific Information Only:**

- ❑ History and Physical — Specify Date: _____
- ❑ Medications/Therapy
- ❑ Lab, Path, EKG — Specify Date: _____
- ❑ X-ray — Type: _____ Date Taken: _____ Report: _____
- ❑ Operative Report — Type of Operation: _____
- ❑ Accident or Injury — Dates From: _____ to _____
- ❑ Immunizations
- ❑ Other — Specify: _____

✍ **Protected or Sensitive Information:** I understand that certain information cannot be released without specific authorization as required by State/Federal Law. **BY INITIALIZING**, I authorize the release of the following protected or sensitive information:

_____ DRUG ABUSE DIAGNOSIS/TREATMENT
_____ ALCOHOLISM DIAGNOSIS/TREATMENT
_____ MENTAL HEALTH/TREATMENT
_____ SEXUALLY TRANSMITTED DISEASES
_____ AIDS/HIV TEST RESULTS INCLUDING RISKY BEHAVIORS
_____ SEXUALLY TRANSMITTED DISEASES

Patient Authorization to Release Information

_____
Signature of Patient or Legally Responsible Person Relationship to Patient Date

This authorization is valid for 90 days and may be revoked by the patient (orally or in writing) at any time prior to the 90 days.
Applicable fees will be charged for Release of Information