Diabetes & Endocrinology Specialists, Inc.

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Board Certified in Internal Medicine
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Authorization for Release of Information to Family and/or Friends

Name of Patient _____ Date of Birth _____

Diabetes & Endocrinology Specialists, Inc. is authorized to release health information pertaining to the above named patient to the entities below.

Entity to Receive Information – Initial each that is subject to this authorization:

_____Leave information on voice mail at: _____
_____Give information to spouse
_____Give information to the following persons:

Description of Information to be Released:

_____Financial Information
_____Results for tests and/or x-rays
_____Family Billing Information
_____Medical information as follows:
_____Other information as described:

Rights of the Patient:

I understand that I have the right to revoke this authorization at any time by sending written notification. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State Law. Any information received by this office for our own use will continue to be protected by the Federal and State Privacy Rule.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____

Signature of Patient/Personal Representative Date

_____

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

FAX RELEASE FORM TO: 314-469-0744