Asheville Endocrinology Consultants

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Authorization for Release of Medical Information

Patient Name:_____ Date of Birth: _____

Patient Street Address: _____ SS#: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Alternate Number: _____

I, _____, do hereby authorize Asheville Endocrinology Consultants to release:
Patient Name

Dates of _____

_____ Office Visit Notes _____ Discharge Summary _____ Laboratory Reports _____ ER Reports
_____ Thyroid Scan _____History & Physical _____ Pathology Reports _____ Entire Chart
_____ Bone Density _____ Progress Notes _____ Radiology Reports Other: _____

_____ I do _____ I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infections, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

Information Release To: _____
Name of Company/Agency/Facility/Person

_____ _____ _____ _____
Street Address City State Zip Code

Purpose of Disclosure:

_____ Referral to Specialist _____ Insurance _____ Worker's Comp _____ Change of Doctor
_____ Legal Investigation _____ Disability Det. _____ Personal _____ Continuing Care
Other (Specify) _____

Please provide a current telephone number in the even we need to contact you: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulation. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of individual or guardian or personal representative of patient's estate **Date**

NOTE: There will be a charge for a personal copy or the permanent transfer of your records. Smart Corporation has been contacted to provide this copy service and will invoice you directly.

Medical Information Released by Smart Corporation

Entire _____ Lab _____ EKG _____ _____
DS _____ OP _____ X-Ray _____ ROI Specialist
HP _____ Path _____ Other _____ _____
Number of Pages _____ Date