



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 _____