Asheville Endocrinology Consultants

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I authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize [ ] do NOT authorize [ ] Asheville Endocrinology Consultants, P.A. personnel to leave messages on my answering machine or voice mail.

_____ _____
Signature of patient or guardian Date

Witness: _____

For office use only: Staff member place form in "to be scanned box".

Medical Records: **Scan** document as **"DIAF" with appropriate AEC physician and pick to scan to both dm and emr.**