DIABETES & ENDOCRINE CENTER OF ORLANDO, PA

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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (MEDICAL RECORD)

PLEASE COMPLETE ALL FIELDS

SECTION A: Must be completed for ALL Authorizations

By signing this Authorization, I hereby authorize and permit the use and/or disclosure of my protected health information (medical record) for the limited purpose(s), and in the limited manner, described in this form. In addition, I understand that this Authorization is completely voluntary and I am signing it under my own free will.

Patient Name: _____ Patient #_____

Home Address: _____ Date of Birth: _____

Persons/organizations providing the information: (Complete w/Address)

Persons/organizations receiving this information: (Complete w/Address)

Specific description of information (including date(s)) to be used and/or disclosed about me:

*** The following items must be initialed to be included in the use or disclosure of other health information:**

- ☐ * HIV / AIDS related health information and/or records.
- ☐ * Mental health information and/or records.
- ☐ * Genetic testing information and/or records.
- ☐ * Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the disclosure of such information.)

SECTION B: MUST BE COMPLETED ONLY IF DIABETES & ENDOCRINE CENTER OF ORLANDO, PA HAS REQUESTED THE AUTHORIZATION

1. DECO must complete the following:
   a. What is the purpose of the use or disclosure? (Check one.)
      - ☐ At the patient's (or the patient's representative's) request or direction.
      - ☐ For marketing.
      - ☐ For fundraising.
      - ☐ Other (describe):

2. The patient or the patient's representative must read and initial the following statements:

   a. I understand that my health care and the payment for my health care will NOT be affected if I DO NOT sign this form. Initial: _____

   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. Initial: _____

SECTION C : Must be completed for ALL Authorizations

The patient or the patient's representative must read and Initial the following statements:

I understand that this Authorization will expire. (Please choose 1 of the 3 options listed below):

a. No expiration (permitted only for Authorizations used to create or maintain research databases or repositories). Initial: _____

b. On _____ (DD/MM/YYYY) Initial: _____
   Date

c. When the following event occurs [ ] Initial: _____

_____ _____
Signature of Patient or Patient's Representative Date
(Form MUST be completed before signing)

Print Name of Patient's Representative: _____

Relationship to the Patient: _____

Reason Authorization is signed by the Patient's Representative: (Check one)

- ☐ Minor
- ☐ Incompetent
- ☐ Other (Explain) _____

*** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**

*If this Authorization form authorizes use and/or disclosure of psychotherapy notes, it may not be used to authorize the use and/or disclosure of any other protected health information. A separate Authorization form is needed for any other use and/or disclosure.