NORTHEAST FLORIDA ENDOCRINE & DIABETES ASSOCIATES, P.A.

Authorization to Release and Disclose Patient Information

Please return via FAX to (904) 486-2314

Patient Information	Name:_____ Date of Birth:_____ Address:_____ Day Phone:_____ City:_____ State:_____ Zip:_____ Last 4 Social Security Number:_____
Clinic/Hospital/Health Care Provider (**WHO** has the information you want released?) Please list the specific Hospital and/or clinic.	Name:_____ Address:_____ Day Phone:_____ City:_____ State:_____ Zip:_____
Receiving Party (**WHERE** do you want the information sent? **WHO** may have the information?)	Name:_____ Address:_____ Day Phone:_____ City:_____ State:_____ Zip:_____ Fax Number (URGENT PATIENT CARE ONLY)_____
Information to be Released (**WHAT** do you want sent or released? Check the appropriate box.)	Routine Record Sets (indicate date(s) of service_____ ____ Clinic (office visit, lab, radiology, medicines, immunization) ____ Hospital (history and physical, discharge summary, operative report, consultations, emergency room, laboratory, radiology) ___ Billing Records ___ Copies of Films/Images ___ Any and all records (includes ALL types of records listed below. If you want to include images and billing records, check those boxes) Only record types checked below: ___Discharge summary note ___Radiology reports ___Emergency record(s) ___Medication records ___History & physical exam ___Pathology reports ___Operative report ___Laboratory reports ___Pathology slides/blocks ___Progress/clinic notes ___Consultations ___Retinal exam results ___Immunization/allergy records ___Other records specify record type(s)_____

Authorization to Release Super-Confidential Information

***Required** – Please complete the checked boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one		initial each line below
I ☐ DO	☐ **DO NOT** want information about ***Mental Health** released	_____
I ☐ DO	☐ **DO NOT** want information about ***HIV Tests & Related Information released**	_____
I ☐ DO	☐ **DO NOT** want information about ***Alcohol and/or Substance Abuse released**	_____
I ☐ DO	☐ **DO NOT** want information about ***Sexually Transmitted Diseases released**	_____

Release Instructions (**HOW** and **WHEN** do you want the information?)	Date information is needed:_____ Release Method/Format request: (check one) ___ Paper ___ Fax (patient care only) __ Electronic
Purpose of Release (**WHY** is it needed?)	___ Continuing Care ___ Transfer of Care ___ Insurance application ___ Personal use or review* ___ Insurance payment/claim ____ Other* _____ **Fees may be charged*

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here:_____
- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. The NEFEDA Health Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- NEFEDA will not restrict my treatment if I choose not to sign this authorization.
- A photocopy/fax of this authorization will be treated in the same way as an original.
- NEFEDA records may include records that it received from other organizations. If these records have been used by NEFEDA and filed in the record NEFEDA maintains about you, these records may be released with your NEFEDA records.
- NEFEDA cannot prevent redisclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release NEFEDA from any and all liability resulting from a redisclosure by the recipient.
- Your signature indicates that you have read and understand this form, and authorize release of your information as described above.

Patient / Legal Guardian Signature	Date	Legal Authority to act on behalf of patient (attached document)