ENDOCRINOLOGY AND DIABETES ASSOCIATES, LCC
201 SIVLEY ROAD SUITE 450
HUNTSVILLE, AL 35801
PHONE 256-551-4505 FAX 256-551-4474
BOBBY N. JOHNSON, M.D. STEVEN L. COWART, M.D.

Authorization for Release/Request of Protected Health Information

Circle one of the following:

RELEASE TO: OBTAIN FROM:

Doctor or Facility Information:

Name:_____

Address:_____

Phone:_____Fax:_____

Patient Information:

Name:_____

Address:_____

Date of Birth:_____Phone:_____

Purpose for this Request: ___Treatment__Request of the Patient_____Billing/Claims
_____Other (specify)_____
_____Dates Requested_____
_____All Medical Records

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility for disclosure of the above information to the extent indicated and authorized herein.

I understand that Endocrinology and Diabetes Associates, LLC may not condition my treatment on whether I sign this authorization form unless specified above under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I understand that if my records contain any history of treatment of psychiatric illness, alcohol, drug abuse, infectious disease, and HIV testing, I consent to the release of such information and relieve the Physicians, officers, directors, agents and servants of Endocrinology and Diabetes Associates, LLC from any liability which I might otherwise be entitled to claim under statue or code law. I authorize Endocrinology and Diabetes Associates, LLC to disclose the protected health information specified above.

Signature:_____Date:_____

(If the Insured is unable to sign, an authorized person may sign):

Authorized Person's Signature_____Date:_____