Endocrinology Associates, Inc.
72 West Third Ave., Columbus, Ohio 43201
614-453-9999 (phone) 614-453-9998 (fax)

HIPAA AUTHORIZATION FORM

Patient's Full Name _____ Patient's Medical Record Number _____

Address _____ Patient's Date of Birth _____

City, State Zip Code _____ Patient's Telephone Number _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about me:

   _____
   His/her/its Name

   _____
   Address

   _____
   Phone Number/Fax Number

3. The specific information that should be disclosed is (please give dates of service if possible):

   _____

   _____

   _____

   UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
   YES, DISCLOSE THIS INFORMATION *_____
   NO, DO NOT DISCLOSE THIS INFORMATION * _____

4. 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 privacy regulations.
5. I may revoke this authorization by notifying Endocrinology Associates, Inc. in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____.
7. This authorization expires one year from the date of signing.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies.
THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

_____	_____	_____
Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth**

OR, if applicable –

_____	_____	_____
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only

_____	_____	_____
Received	**Processed By**	**Transmission Method**