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Endocrinology Associates, Inc.
3501 Colonial Green Circle
Roanoke VA, 24018
Phone (540) 344-3276 ☐ Fax (540) 342-4399 PT Chart # _____

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL INFORMATION

Patient Name: _____ DOB: _____
Address: _____ City: _____ State: _____
Phone: _____ SSN: _____

RELEASE TO:
I authorize ENDOCRINOLOGY ASSOCIATES to release information contained in my medical record to:

_____
Name of Facility

_____
Address

_____
City State Zip Code

Phone # : ( ) _____
Area Code

Fax # : ( ) _____
Area Code

OBTAIN FROM:
I authorize the following healthcare facility to release my medical records to Endocrinology Associates:

_____
Name of Facility

_____
Address

_____
City State Zip Code

Phone # : ( ) _____
Area Code

Fax # : ( ) _____
Area Code

INFORMATION TO BE RELEASED:
Clinical progress notes: _____ Complete medical record: _____ X-Ray reports: _____
Laboratory reports: _____ EKG reports: _____ Other: _____

PURPOSE OF RELEASE:
Transfer of care: _____ Continuity of care: _____ Referral to specialist: _____
Doctor's request: _____ Personal: _____ Other: _____

_____ I DO _____ I DO NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) of HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment for alcohol and/or drug abuse.

I hereby authorize disclosure of the health information for the above patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with the written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class or persons or facility receiving it and would then no longer be protected by Federal Regulations. I understand that the medical provider to who, this is furnished may not condition its treatment of me whether or not I sign the authorization.

_____ _____
Signature of individual or guardian or Personal representative of patient's estate — Date

NOTE: There will be a charge for a personal copy or the permanent transfer of your records. CIOX has been contracted to provide this service and will invoice you directly.