STONESIFER ENDOCRINE CARE
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# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I, _____, DOB _____, hereby authorize the office of Dr. Larry D. Stonesifer M.D./Marcia K. Miller, ARNP/ Marjorie Sladek, ARNP to disclose healthcare information to:

## INFORMATION TO BE SENT TO:

_____
Name of designated recipient

_____
Address

_____ (___)_____ (___)_____
City, State, and Zip Phone Number Fax Number

## INFORMATION TO BE RELEASED:

___ Healthcare information relating to the following treatment, condition or dates of treatment

_____.

___ All healthcare information including records of testing and/or treatment for drug alcohol dependence, psychiatric or mental health disorders or sexually transmitted disease including AIDS or transsexualism.

____ I do NOT consent to the release of the following records:
( ) Sexually transmitted disease ( ) HIV
Testing results of Treatment ( ) Substance Abuse – Alcohol/Drug
( ) Mental health or Psychiatric Disorders ( ) Transsexualism

____ Other _____.

Purpose for which disclosure is being made: (Please check on of the following)

___ Attorney ___Insurance ___Doctor ___Personal

## My Rights:

I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, and enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the privacy notice to our patients. I understand that one the above named facility disclosed health information, the person or organization that received it may re-disclose it, at which time it may no longer be protected under privacy laws. If you desire a copy of this authorization please notify a representative of the medical records department upon completion of this form.

SIGNATURE: _____ DATE: _____
(Patient, Guardian, or Authorized Representative)

**Please provide documents to prove authority to sign on behalf of the patient.**
**This authorization will expire 90 days from the date signed. Possible copying fee required.**