Emerald Coast Diabetes & Nutrition Center
217 Miracle Strip Pkwy
Fort Walton Beach, FL 32548

AUTHORIZATION TO **RELEASE** PROTECTED HEALTH INFORMATION

Patients Printed Name: ____
(LAST) (FIRST) (M.I.)

Address: ____
(STREET) (CITY) (STATE) (ZIP)

Date of Birth:__________________SSN:_______-_____-______Daytime Phone: ___________________
(MM/DD/YYYY)

I hereby authorize and request (provider name, address, & phone) _________________________________

____

to **release** a copy of the following protected health information to
____
____
____

Description of information to be disclosed: Specify Service Date(s) ___
______Medical Transcript(s) ______Radiology Report(s) _____Lab Result(s)
_____Medication Sheet(s) _____Pathology Report(s) _____Other

PLEASE MAIL IF MORE THAN 25 PAGES

I understand that:

1. The release of information may contain alcohol use, drug abuse, HIV results, AIDS or any other sexually transmitted disease information
2. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken **prior to receiving the revocation.**
3. I understand that protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient, and the privacy of my protected health information may no longer be protected by law.
4. Emerald Coast Diabetes & Nutrition Center, its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility or liability that may arise from the release or reproduction of such records and/or information in accordance with this authorization.
5. I may inspect and obtain a copy of the protected health information described on this form, for a reasonable fee, if I ask for it after signing this authorization form.

I have read the above and authorize the disclosure of the protected health information as stated.

______________________________ ____________________
(PATIENT SIGNATURE) (DATE)