Arkangel Endocrinology & Diabetes, PLLC
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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION **(RECORDS RELEASE)**

Date:	
Patient Name:	DOB:

I authorize **Arkangel Endocrinology & Diabetes, PLLC** to release my confidential health information to the following person/organization:

Person/Organization Name:	
Phone:	Fax:

Purpose of Release: (Check all that apply)
☐ Continuation of Care ☐ Disability ☐ Insurance ☐ Personal Use ☐ Other: _____

Person/ Organization requesting records: (Check all that apply)
☐ Patient/ Parent/ Patient Representative/ Legal Guardian ☐ Physician/Physicians Practice/Hospital ☐ Other: _____

Information to be disclosed:
☐ All of my health information that the provider has in his/her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

☐ **Only the following records or types of health information:**
- ☐ Laboratory/ Pathology Testing: _____
- ☐ Medical Imaging: _____
- ☐ Consult Notes: _____
- ☐ Procedure/Surgery Notes: _____
- ☐ Other: _____

By signing this form, I authorize Arkangel Endocrinology and Diabetes, PLLC to release confidential health information about me by releasing a copy of my medical records or a summary or narrative of my protected health information to the physician/person/facility/entity listed above.

Name:	Signature:	Date:

If individual is unable to sign this Authorization, please complete the information below:

Name of Guardian/Representative:	Signature:
Relationship to Individual:	Date: