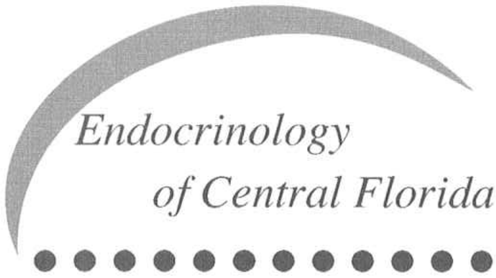

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Board Certified in Endocrinology, Diabetes and Metabolism

CONSENT FOR RELEASE OF INFORMATION FROM ENDOCRINOLOGY OF CENTRAL FLORIDA

1. I hereby authorize **ENDOCRINOLOGY OF CENTRAL FLORIDA** to release information including, if any, psychological information, infections or contagious disease information, and/or information about drug or alcohol abuse or treatment of same from the health records of:

2. PATIENT NAME:________________________________ DOB:______________
(please print)
SOCIAL SECURITY # :____________________________ PHONE:____________

PATIENT ADDRESS:______________________________ __________________

3. Covering the period(s) of treatment: All records_____
From:______________ To:________________

4. Information to be released: Complete Chart_____ Other:______________________

5. Information to be released to:
Name: ____
Address: ____
____

Phone: _(___)_____________________
Fax: _(___)_____________________

6. Purpose of disclosure: ____

7. I hereby release Endocrinology of Central Florida and its employees, agents, officers, and affiliates from any and all liability, responsibility, claims and damages which may result from the release of information authorized by this Consent for Release of Information.

8. I understand that this Release of Information is subject to revocation by the undersigned at any time, except to the extent that action had already been taken by Endocrinology of Central Florida in reliance upon this consent. Unless otherwise stated below, this consent shall automatically expire one year from the date set forth below, or upon the following date, event or occasion:__________

9. I have read and understand the Consent for Release of Information, and have voluntarily and knowingly signed such consent.

Signature of Patient:____________________________________ Date:___________

Signature of Legal Representative:__________________________ Date:___________
(proof of Legal Representation mandatory)

Witness:____ Date:___________

v.11/2016