DGDClinic
Diabetes & Glandular Disease Clinic, P.A.
LEADING THE SEARCH FOR BETTER HEALTH

Pt ID #:_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of information from the medical record of:

Patient Name: _____ DOB: _____

Social Security # (Optional): _____ Phone: (Optional): _____

Information Released TO: FROM:

_____ _____

_____ _____

_____ _____

Please Release the Following:

- ☐ Problem List
- ☐ Progress Notes
- ☐ History/Physical Exam
- ☐ Lab Reports
- ☐ Immunizations
- ☐ X-Ray Reports
- ☐ X-Ray Films
- ☐ EKG Reports
- ☐ Other Diagnostic Reports (Specify)_____
- ☐ Other (Specify)_____

Including information (if applicable) pertaining to:

☐ Mental Health ☐ Drug/Alcohol/Substance Abuse ☐ HIV/AIDS ☐ Genetic

Requested Format	**Purpose or Need for Disclosure**	
☐ Printed	☐ Continued Patient Care	☐ Personal Use
☐ PDF	☐ Attorney/Legal	☐ Insurance Claim/Application
☐ Via Patient Portal	☐ Disability Determination	☐ Other (Specify)_____
	☐ School	☐ Employment

I understand that the information released is for the specific purpose(s) stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Legal Representative's Printed Name and Relationship to Patient Witness

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT.

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Diabetes & Glandular Disease Clinic, P. A. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Legal Representative's Printed Name and Relationship to Patient Witness