

ANN ARBOR

**Endocrinology
& Diabetes**
ASSOCIATES, PC

5333 McAuley Drive
Reichert Health Building
Room 6014
Ypsilanti, Michigan 48197
734.434.4430
www.annarborendo.com

**PATIENT AUTHORIZATION
FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION**

Patient's Name: _____ Date of Birth: _____

Previous Name (or previous name upon which health care was provided) _____

I request and authorize Ann Arbor Endocrinology & Diabetes Associates, P.C. to release health care information of the patient named above to:

Name or organization: _____

Address: _____

City, State: _____ Zip Code: _____

This request and authorization applies to:

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____ All health care information (excludes billing)

_____ Other: _____

This information will be disclosed to facilitate patient's personal health care or be used as part of review of patient's health (i.e. employers, workers' compensation, social security agencies, disability claims, life or health insurance claims, or in cases of medical-legal matters/disputes). You are not required to identify specific reasons for disclosing/releasing health care information unless you feel it will facilitate your health care.

Please use this line to include any additional information you would like us to know in disclosing or releasing your medical information. _____

Signature of patient or patient's authorized representative Date Signed

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)_____

THIS AUTHORIZATION EXPIRES ON: _____;
OR 90 DAYS AFTER THE DATE IT IS SIGNED;
OR WHEN THE FOLLOWING EVENT OCCURS:

I may revoke this authorization to the extent allowed by law. If I do, I understand that Ann Arbor Endocrinology and Diabetes Associates, P.C. may have already released information about me after I gave permission. I know that revoking this authorization would not prohibit any release of information by Ann Arbor Endocrinology and Diabetes Associates, P.C. in reliance on my original authorization. I may revoke this authorization in writing to the extent allowed by law. Once Ann Arbor Endocrinology and Diabetes Associates, P.C. gives out the information that I want released, I know that Ann Arbor Endocrinology and Diabetes Associates, P.C. has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

Ann Arbor Endocrinology and Diabetes Associates, P.C. will accommodate all reasonable requests within 15 business days.

The estimated cost to you to have this information sent is _____.

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**ACKNOWLEDGEMENT
RECEIPT OF NOTICE OF PRIVACY PRACTICES
Ann Arbor Endocrinology and Diabetes Associates, P.C.**

By signing below, I acknowledge that I have received the *Notice of Privacy Practices*
From Ann Arbor Endocrinology and Diabetes Associates, P.C.

WITNESSES:

Patient Signature

Date

Witness Signature

Date

Any specific requests/requirements: _____

Documentation of Failure to Obtain Signed Acknowledgement

On _____, _____ presented this Acknowledgment of
(day/mo/yr) (name of employee)
Receipt of Notice of Privacy Form to _____. The patient refused
to provide a signature when requested.