ENDOCRINE CLINIC OF SOUTHEAST TEXAS
3030 NORTH STREET, SUITE 560
BEAUMONT, TEXAS 77702

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize the following physician:

_____ at the following address:

_____to use and disclose to the following party:
The Endocrine Clinic of Southeast Texas, located at 3030 North Street, Suite 560, Beaumont, Texas 77702
Fax: (409) 835-7623
Phone: (409) 835-9834

The use and disclosure will be made by the office staff of this facility.

The health information to be used and/or disclosed is specifically described as follows (check all information to be released):

_____Lab _____Echo _____Stress Test _____EKG _____Ultrasound
_____Ultrasound _____Thyroid Uptake and Scan _____ X-ray Report
_____DEXA (Bone Density) _____Progress Notes _____Other

This authorization shall be in force and effective until the following event and/or date:
_____at which time this authorization to use or disclose this protected health information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the aforementioned facility. I understand that a revocation is not retroactive to the extent that the facility has already used/disclosed information based on this current authorization. Also, a revocation is not effective if this authorization was a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

The facility will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand I have the right to : 1) Inspect or have a copy of the protected health information to be used or disclosed as permitted under federal law (or states law to the extent state law provides greater access rights), 2) Refuse to sign this authorization; in which case we will be unable to process this request.

_____
Signature of Patient or Personal Representative

_____
Date

_____
Date of Birth

_____
Social Security #

_____
Name of Patient or Personal Representative