LAKESIDE ENDOCRINE ASSOCIATES

1667 N. Clyde Morris Blvd Ste 2 Daytona Beach FL 32117

Phone: (386) 274-1414 Fax: (386) 274-2215

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient:____

Home Address:____

Telephone: ____ **Date of Birth**: _____________________

SPECIFY INFORMATION TO BE DISCLOSED: (Check one, or all that apply)

- ☐ Demographics
- ☐ Lab / Test Results, specify: ____
- ☐ Entire Medical Records
- ☐ History & Physical
- ☐ Medication List
- ☐ Other, specify:____

By applying a check mark below, I acknowledge that highly confidential information listed below can be disclosed: (May waive this section if not pertinent)

- ☐ Mental Illness, Developmental Disability, Psychotherapy Notes, HIV/AIDS testing, STDs, Abuse or Sexual Assault, Child Neglect/Abuse or Other.

RECIPIENT: Name of the persons who **LAKESIDE ENDOCRINE ASSOCIATES** may disclose my health information:
NAME:____
ADDRESS:____
TERM: This Authorization will remain in effect:

- ☐ From the date of this authorization until the __________day of_____________, 20_______
- ☐ Until covered entity fulfills this request.
- ☐ Until the following event occurs: ____

PURPOSE: I authorize LAKESIDE ENDOCRINE ASSOCIATES to use or disclose my health information (including highly confidential, if selected above) during the term of this authorization for the following specific purpose(s):

- ☐ Continuity of Care
- ☐ Personal
- ☐ Legal
- ☐ Insurance
- ☐ Other: ____________________________________

I understand that once LAKESIDE ENDOCRINE ASSOCIATES disclosed my health information to the recipient, Lakeside Endocrine cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state laws governing the use and disclosure of my health information.
I understand that I may refuse or revoke this authorization (at any time) for any reason and that such refusal or revocation will not effect the commencement continuation or quality of my treatment at Lakeside Endocrine Associates.
I understand this authorization will remain in effect until the term of this authorization expires or I provide written notice of revocation to the Lakeside Endocrine Associates Privacy Officer at the address listed below. The revocation will be effective immediately upon Lakeside Endocrine Associates receipt of my written notice.
I may contact Lakeside Endocrine Associates by mail at:

Lakeside Endocrine Associates Privacy Officer 1667 N. Clyde Morris Blvd Suite 2 Daytona Beach FL 32117

My signature below states that I have read and understand the Authorization about the use and disclosure of my health information.

Patient Signature:____ **Date:** _______________________________