ANN ARBOR
Endocrinology & Diabetes
ASSOCIATES, PC

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PATIENT AUTHORIZATION FOR 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 a part of review of patient's health (i.e. employers, workers' compensation, social security agencies, disability claims, life of 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.