VEA | VALLEY ENDOCRINE ASSOCIATES, PC

ROBERT C. BIESBROECK, MD,FACP, FACE • GYAN BRARD. MD,FACE • SHAHZAD SHADMANY, MD, FACE • MAUREEN GASTON, FNP

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: DOB:

☐ Please request records from the following person/entity:
☐ Please release my records to the following person/entity:

Person/Entity Phone Fax

Please send records from: _____ to _____. **Please send all records** ☐
(Date) (Date)

In addition to the general authorization to release records to the person or entities listed above, I authorize the release of the records described as the following:

Communicable disease-released information, including records of testing, diagnosis, or treatment for HIV, HIV-released illness, AIDS, AIDS-related diseases ☐ Yes ☐ No

Drug and alcohol treatment ☐ Yes ☐ No

Psychological/psychiatric information, including diagnosis and treatment ☐ Yes ☐ No

Pathology slides, x-rays, videotapes, photographs ☐ Yes ☐ No

Genetic screening ☐ Yes ☐ No

This authorization is valid for six (6) months from the date of signing and may be revoked at any time by providing written notice of revocation. I understand I cannot revoke this authorization retroactively for information already released. I understand when Valley Endocrine Associates, P.C. discloses PHI pursuant to this authorization, we can no longer guarantee confidentiality to prevent re-disclosure, and the information may no longer be protected by federal privacy rules. I understand by signing this authorization, I agree to allow Valley Endocrine Associates, P.C., and all their staff members to disclose the following protected health information to the above stated person(s) and entity**. I understand that there may be a $30.00 fee for copies of medical records.**

Patient Signature Date

Legally Authorized Representative Relationship to patient Date

Witness Date

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