HIPAA Privacy Authorization Form

Request for Release of Medical Records

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize _____ _____(healthcare provider) to release and disclose my protected health information described below to

Norman Parathyroid Center
2400 Cypress Glen Drive
Wesley Chapel, Fl 33544
Phone: 813-972-0000
Fax: 813-972-0077

James Norman, MD, FACS, FACE
Jose Lopez, MD, FACS
Douglas Politz, MD, FACS, FACE
Rafael Toro, MD

2. Effective Period
This authorization for release of information covers the period of healthcare from:

a. □ _____ to _____ *OR _____ **All dates of service**

3. Extent of Authorization

a. □ I authorize the release of all records listed below:

*__All lab reports__
*__Recent DEXA/Bone density tests__
*__Progress notes pertaining to high calcium/parathyroid issues__
*__Results from any parathyroid scans (sestamibi or thyroid ultrasound)__
*__Any records pertaining to neck surgery, thyroid/parathyroid procedures__

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative_____ D.O.B._____/_____/_____

Phone Number_____

Printed name of patient or personal representative and relationship to patient_____

Date_____/_____/____