# 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

## Authorization

**Please print patient name below.**

_____ **DOB:** _____/_____/_____

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

Norman Parathyroid Center
5959 Webb Road
Tampa, FL 33615
Phone: 813-972-0000
**Fax: 1-888-481-1487**

## Effective Period

This authorization for release of information covers the period of healthcare from:

## Extent of Authorization

I authorize the release of all records listed below:

***Last two years Calcium (Serum/Ionized), PTH, Vitamin D labs**
***Most recent CMP**
***Most recent DEXA/Bone density tests**
***Last office note pertaining to high calcium/parathyroid issues**
***Results from any parathyroid scans (sestamibi or thyroid ultrasound)**
***Operative and Pathology reports pertaining to neck surgery, thyroid/parathyroid procedures**

- 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.
- 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.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- 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

_____

Date: ____/____/_____ Phone Number_____