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

Printed name of patient or personal representative and relationship to patient

_____ Date _____/_____/_____

I authorize _____ (healthcare provider) to release and disclose the 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 · Douglas Politz, MD, FACS, FACE · Jose Lopez, MD, FACS
Dan Ruan, MD, FACS, Deva Boone, MD · Jamie Mitchell, MD, FACS · Kevin Parrack, MD

Effective Period

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

_____ to _____ OR _____ All dates of service

Extent of Authorization

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**

- 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 the disclosed information may, unless expressly limited by me in writing, include information relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, and/or mental or behavior health or psychiatric care.
- 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 _____

D.O.B.____/____/_____ Phone Number_____