

AUTHORIZATION

DIABETES & ENDOCRINOLOGY CENTER OF OHIO, INC.
7281 Sawmill Rd., Ste 100
Dublin, Ohio 43016
614.764.0707

Authorization to Release Protected Health Information to Diabetes & Endocrinology Center of Ohio, Inc.

I hereby authorize (organization/facility/person) _____

Patient Name Date of Birth

Please send the medical records to Diabetes & Endocrinology Center of Ohio, Inc via the following method:

Mail: ATTN: _____
C/O Diabetes & Endocrinology Center of Ohio, Inc 7281 Sawmill Rd., Ste 100 Dublin, OH 43016

OR
Fax: ATTN: _____ **Fax Number: 614.764.1707**

Description of Records to be released/disclosed:

Specify Dates:

The purpose of the authorized use or disclosure described above is as follows:

- Transfer of records to new treatment provider
- Insurance Review or Dispute
- Attorney review
- School examination
- Personal Use
- Other (be specific) _____

Other Information:

1. As described in the Notice of Privacy Practices of Diabetes & Endocrinology Center of Ohio, Inc, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by DECO in reliance on this authorization, by sending a written revocation to Diabetes & Endocrinology Center of Ohio, Inc 7281 Sawmill Rd., Ste 100 Dublin, Ohio 43016.
2. I understand that I am not required to sign this authorization form and that DECO, Inc will not condition the provision of treatment or payment to me on the signing of this form.
3. I understand that in this authorization includes the use and/or disclosure of information from the patient medical or financial records as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS related conditions to the above mentioned entity(s).
4. I understand that if the person or entity that receives the above information is not a health care provider covered by federal privacy regulations, the information described may be redisclosed by such person or entity and will likely no longer be protected by federal privacy regulations.

This authorization will automatically expire 60 days from the date it is signed if no expiration option is indicated below:

*** Insert applicate date or specific event:** _____

Signature of Patient/Legal Representative Date

Address

Doctor Name: _____ Doctor Fax: _____