Endocrinology Associates of Montgomery, P.A.

Bruce S. Trippe, M.D., F.A.C.E.
2030 Chestnut Street • Montgomery, Alabama 36106
Phone: (334) 834-2940 • Fax: (334) 834-8959

Authorization for Release of Information

I (patient / legal guardian) _____ authorize to release the records and other information regarding my treatment and/or outpatient care for my condition, including psychological or psychiatric impairment, drug and/or alcohol abuse, or Acquired Immunodeficiency Syndrome (AIDS), or tests for or infection with Human Immunodeficiency Virus (HIV) from my records now in the possession of _____.
I agree that the information released will be limited to information necessary to fulfill the need or purpose for the disclosure.

RE: Patients Name _____

Date of Birth _____ Date of Treatment _____

Reason for release of information _____

Release information to: Name _____

Address _____

_____

Information to be released:

- ○ General Abstract
- ○ History / Physical
- ○ Pathological Reports
- ○ Progress Notes
- ○ X-Ray Reports
- ○ Other _____
- ○ EKG / EEG
- ○ Operative Reports
- ○ Laboratory Results

I understand that my records are protected under Federal Confidentiality Regulations (Federal Register, Part IV, July 6, 1975) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken on it. This authorization will automatically expire in six months. There will be a charge for records copied to an outside source other than a government agency.

_____ _____
Patient / Legal Guardian Date

_____
Telephone Number

_____ _____
Witness Date

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