ENDOCRINE ASSOCIATES OF FLORIDA, P.A.
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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize and request release of the following:

_____ A copy of the most recent doctor notes, laboratory results, imaging.

_____ Complete chart including reports, laboratory results, imaging, and medication.

MEDICAL RECORDS FROM:
Name of facility/person
to receive information from: _____

Address: _____

City, State, Zip: _____

RELEASE MEDICAL RECORDS TO:
Name of facility/person
to receive information: _____

Address: _____

City, State, Zip: _____

TO RECEIVING PARTY: The information is disclosed to you from records whose confidentiality is protected by law. Re-disclosure is prohibited without the written permission of the patient/client/legal representative listed above.

TO REQUESTING PARTY: I understand signing this document releases Endocrine Associates of Florida, P.A., from all legal responsibility and/or liability arising from the release of such records. Florida Statute has established guidelines and cost rates for copying of medical records. Your signature indicates your knowledge of this statement.

NOTE: PATIENT/REPRESENTATIVE MUST INITIAL APPLICABLE AREAS FOR RELEASE.

Psychiatric/psychological information _____ (Initials)
Alcohol/drug/chemical information _____ (Initials)
HIV tests and information pertaining to tests/treatment _____ (Initials)

Patient's Name (printed): _____ Date: _____

Address: _____ SS# _____ DOB_____

Patient/Guardian Signature: _____ Account # _____

Witness Signature: _____ Date: _____

ENDOCRINE ASSOCIATES OF FLORIDA, P.A.

Date_____ DOB_____ Age_____ Patient Name_____

PAST MEDICAL HISTORY (*Have You Had These?*)

Yes	No		Yes	No	
___	___	High Blood Pressure	___	___	Retinopathy
___	___	Arthritis	___	___	Peptic Ulcer
___	___	Pneumonia	___	___	Gall Bladder Disease
___	___	Diabetes	___	___	Bowel Disorder
___	___	Thyroid Disease	___	___	Liver Disease
___	___	High Cholesterol	___	___	Kidney Stones
___	___	Asthma/Emphysema	___	___	Kidney Disease
___	___	Heart Disease	___	___	Stroke
___	___	Bleeding Disorders	___	___	Epilepsy
___	___	Radiation Treatments	___	___	Cataracts
___	___	Tuberculosis	___	___	Gout
___	___	Cancer	___	___	Anemia
___	___	HIV	___	___	Bladder Infections
___	___	Amputations	___	___	Neuropathy
___	___	Pituitary Disease	___	___	Parathyroid Disease

FAMILY MEDICAL HISTORY (*Have Any Blood Relatives Ever Had?*)

Yes	No		WHO	Yes	No		WHO
___	___	Diabetes	_____	___	___	Cancer	_____
___	___	Thyroid Disease	_____	___	___	Pituitary Disease	_____
___	___	High Blood Pressure	_____	___	___	HIV	_____
___	___	Heart Disease	_____	___	___	Abnormal Bleeding	_____
___	___	Adrenal Disease	_____	___	___	Hepatitis	_____

SOCIAL HISTORY

Married _____ Single _____ Divorced _____ Widowed_____ Separated _____

Have you used tobacco? Yes ___ No ___ # of packs per day _____ For how many years? _____

Have you used alcohol? Yes ___ No ___ How much per day _____ For how many years? _____

Do you use caffeine? Yes ___ No ___ Coffee/day _____ Cola/day _____ Tea/day _____

Do you exercise regularly? Yes ___ No ___ Are you on a regular diet? _____

Do you use any illicit drugs or cannabis oil? Yes ___ No ___

LIST CURRENT MEDICATIONS

Name	Dose	Amount Take Each Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES (*To the following medications, Please Check*)

Penicillin _____ Sulfa _____ Aspirin _____ Tetanus _____ Serum _____

Antibiotics _____ - *Please Name*: _____

Other - *Please Specify*: _____