

**FULL LIFE HORMONE SPECIALISTS, LLC**

**AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

**PATIENT'S NAME** \_\_\_\_\_  
Last First Middle

**ADDRESS** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_ **PHONE** ( \_\_\_\_\_ ) \_\_\_\_\_

**SOCIAL SECURITY NUMBER** \_\_\_\_\_

**ORGANIZATION PROVIDING INFORMATION**

**ORGANIZATION REQUESTING INFORMATION**

\_\_\_\_\_  
Name of Health Care Provider

\_\_\_\_\_  
Name of Health Care Provider

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
City/State/Zip

( \_\_\_\_\_ ) \_\_\_\_\_  
Area Code / Telephone

( \_\_\_\_\_ ) \_\_\_\_\_  
Area Code / Telephone

**DELIVERY OPTIONS:** \_\_\_\_\_ Mail-\$5.00 fee to be paid prior to records being mailed.  
\_\_\_\_\_ Pick-up/Hand carry-no fee (Date & Time) \_\_\_\_\_  
\_\_\_\_\_ Authorized person to pick up health information \_\_\_\_\_  
\_\_\_\_\_ View On-Site only \_\_\_\_\_ Other \_\_\_\_\_

**HEALTH INFORMATION TO BE DISCLOSED:** (Check all that apply)

\_\_\_\_\_ ALL Medical Records \_\_\_\_\_ Medical/Chart notes \_\_\_\_\_ Operative Reports  
\_\_\_\_\_ Pap Smears \_\_\_\_\_ Mammogram \_\_\_\_\_ Ultrasound Reports  
\_\_\_\_\_ Bone Density Reports \_\_\_\_\_ Laboratory Reports \_\_\_\_\_ Pathology Reports  
\_\_\_\_\_ Other \_\_\_\_\_ For the following dates: \_\_\_\_\_

**Medical records to be released will include information generated by this office only.**

**EXPIRATION DATE OF AUTHORIZATION:** This authorization is effective through \_\_\_\_/\_\_\_\_/\_\_\_\_  
unless revoked or terminated earlier by the patient or the patient's designated representative. If no date  
is specified, this Authorization will expire one (1) year from the date signed.

**PURPOSE OF DISCLOSURE:** (Check all that apply)

\_\_\_\_\_ Further Medical Care \_\_\_\_\_ Patient Request \_\_\_\_\_ Residence Relocation  
\_\_\_\_\_ Insurance Eligibility/Benefits \_\_\_\_\_ Legal Investigations \_\_\_\_\_ Second Opinion  
\_\_\_\_\_ FMLA \_\_\_\_\_ Disability Insurance \_\_\_\_\_ Life Insurance  
\_\_\_\_\_ Other: \_\_\_\_\_

**I DO NOT WANT THE FOLLOWING HEALTH INFORMATION DISCLOSED:**

\_\_\_\_ HIV Test Results      \_\_\_\_ Mental Health Records      \_\_\_\_ Alcohol and Drug Abuse Records

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**RIGHT TO REVOKE AUTHORIZATION:**

By signing below, I understand that I may revoke or terminate this authorization at any time, in writing, before the information has been released by FULL LIFE HORMONE SPECIALISTS, LLC. I further understand that I have a right to receive a copy of this authorization upon request.

**AUTHORIZED SIGNATURE:**

I understand that this information is protected by Federal and Alabama confidentiality laws and that such laws prohibit making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by such laws.

I hereby authorize the use and disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be redisclosed and may no longer be protected by federal privacy regulations. Therefore, I release FULL LIFE HORMONE SPECIALISTS, LLC from any and all legal liability arising from this disclosure of my health information.

I understand that I am responsible for any fees as stated above for the mailing of my health information and I agree to pay the fee in full prior to my records being mailed.

**BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.**

Printed Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Printed Name of Parent, Guardian or Legal Representative: \_\_\_\_\_

Signature of Parent, Guardian or Legal Representative: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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**For Office Use Only:**

Records picked up by: _____	Date: _____	Initials: _____
Records picked up by: _____	Date: _____	Initials: _____
Records picked up by: _____	Date: _____	Initials: _____
Records picked up by: _____	Date: _____	Initials: _____