DIABETES AND ENDOCRINOLOGY ASSOCIATES
OF STARK COUNTY, INC.
4565 DRESSLER ROAD NW, Suite #111
CANTON, OHIO 44718
PHONE (330) 493-0013 • FAX (330) 493-6973
• **Arvind Y. Krishna, M.D. Heidi Daugherty, CNP Laura Fries, FNP Kelli Baker, FNP.**

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: ____

DATE OF BIRTH: ____________________ SS#: ______________________________

I, ______________________________, hereby authorize Diabetes & Endocrinology Associates of Stark County, Inc. to
(check the following that apply): □ obtain the following protected health information, and/or
□ disclose the following health information

To/ From: ______________________________________

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□ Entire medical record
□ Lab/x-ray
□ Medication Flow Sheet
□ Office visit notes/physical
□ Other ______________________________________

The minimum necessary of the above checked items of the protected health information will be released and is being used or disclosed for the following purposes: ______________________________

This authorization shall be in force and effect until ____________________ (*specify date or event that relates to the patient or the purpose of the use or disclosure*), at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to Diabetes & Endocrinology Associates of Stark County, Inc. I understand that a revocation is not effective to the extent that Diabetes & Endocrinology Associates of Stark County, Inc. has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Diabetes & Endocrinology Associates of Stark County, Inc. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

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Signature of Patient or Personal Representative Date

____

Name of Patient or Personal Representative

____

Description of Personal Representative's Authority

____

Witness Date

Records release.doc Rev 9/20/07