AUTHORIZATION TO RELEASE INFORMATION:

THE UNDERSIGNED HEREBY AUTHORIZES SOUTH FLORIDA ENDOCRINE CENTER AND ANY PHYSICIAN WHO PROVIDES SERVICES TO RELEASE INFORMATION (INCLUDING TREATMENT FOR DRUB AND ALCOHOL ABUSE) TO INSURANCE COMPANIES, INDIVIDUALS INVOLVED IN YOUR CARE, OR PAYMENT FOR YOUR CARE, RESEARCH, TREATMENT, REQUIRED BY LAW (FEDERAL,STATE, OR LOCAL LAW) TO PREVENT SERIOUS THREAT TO YOU OR ANOTHER PERSONS HEALTH OR SAFETY, THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR MEDICAL ASSISTANCE PROGRAMS (INCLUDING THEIR AGENTS, REPRESENTATIVES, OR ASIGNEES) OR ANY THIRD PARTY PAYOR THROUGH WHICH PAYMENT OR BENEFITS IN CONNECTION WITH HOSPITAL AND/OR PHYSICIAN SERVICES ARE, OR MAY BE, AVAILABLE. WE DISCLOSE MEDICAL INFORMATION TO CONTACT YOU AS A REMINDER THAT YOU HAVE AN APPOINTMENT FOR TREATMENT AND ALL CHARGES FOR SERVICES ARE DUE AT TIME OF SERICE UNLESS OTHER FINANCIAL ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. THE PATIENT IS REPSONSIBLE FOR ALL FEES REGARDLESS OF COVERAGE.

PATIENT SIGNATURE_____DATE_____

PATIENT AGENT OR REPRESENTATIVE_____DATE_____

HIPPA PRIVACY AKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I HAVE BEEN PRESENTED WITH THE NOTICE OF PRIVACY PRACTICES OF SOUTH FLORIDA ENDOCRINE CENTER (LAMINATED COPAY ATTACHED, I MAY REQUEST A COPY FOR MY RECORDS AT ANY TIME)

PATIENTS SIGNATURE_____DATE_____

PATIENT AGENT OR REPRESENTATIVE_____ DATE_____