Regency Endocrinology, Diabetes, & Metabolism
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENT'S NAME: _____ DATE OF BIRTH: _____

MAIDEN NAME: _____ SSN: _____

Dr. Maha Ansara
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752 Stirling Center Place, Suite 1008
Lake Mary, FL 32746

AUTHORIZATION TO RELEASE OR REQUEST HEALTHCARE INFORMATION

DOCTOR/FACILITY NAME _____

FAX _____

ADDRESS: _____

This request and authorization applies to the following dates _____ to _____ (must be entered) for the below records (please check all that apply):

- ☐ HISTORY AND PHYSICAL NOTES
- ☐ PROGRESS NOTES / OFFICE NOTES
- ☐ X-RAY, ULTRASOUND, MRI, EEG, EKG, SCANS
- ☐ LAB RESULTS
- ☐ PATHOLOGY / OPERATIVE REPORTS
- ☐ EMERGENCY RECORD
- ☐ DISCHARGE SUMMARY
- ☐ ADMISSION SUMMARY
- ☐ MEDICATION LIST
- ☐ COMPLETE RECORD

My signature is approval of my authorization. I authorize the above named provider to release my protected health information to those identified on this release. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by federal and state law which prohibits disclosure with out specific written authorization of the undersigned, or as otherwise permitted by such regulations.

_____ _____

Patient / Legal Representative *Signature Required* Date