MEDICAL AUTHORIZATION FOR RELEASE DISCLOSURE OF PROTECTED HEALTH INFORMATION / HIPAA CONSENT FORM

This is to authorize you to release any information regarding my condition and care to Medicare, my Insurance carrier or Other Healthcare Provider(s) or Referring Physicians directly associated with my care. Also, to authorize Syosset Endocrinology physicians and staff to provide and/or discuss my care with my immediate family (incl spouse, children, parents)

THANK YOU!

SYOSSET ENDOCRINOLOGY MANAGEMENT

PATIENT NAME (PRINT): _____

PATIENT SIGNATURE: _____DATE: _____