MIDTOWN
ENDOCRINE ASSOCIATES

Joan F. Bailey, M.D

2200 N. 3rd Street
Phoenix, AZ 85004
Phone: 602-258-9955 Fax: 602-258-9933

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

Patient Name: _____

In connection with the medical services that I am receiving from the medical professionals at Midtown Endocrine Associates, I hereby authorize the above-named medical professionals and/or Midtown Endocrine Associates to disclose any/or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

A. Any third party payer covering the medical services of the patient;
B. Other health care professionals and institutions involved in the delivery of health care to the patient;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
E. Pharmacies; and
F. Other parties as otherwise required by law.

In each case, Midtown Endocrine Associates shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to Midtown Endocrine Associates privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given:

Special Restrictions:

_____

_____

_____

This consent is valid from the date executed until revoked in writing by the patient.

_____ ____/____/____
Patient Signature Date

_____ ____/____/____
Witness Signature Date