**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

Date: ____________

To: ________________________________________________________________

_______________________________________ ______________________

Patient Name Date of Birth

I, ______________________________________________________, hereby authorize and request that ____________________________ **(NAME OF HEALTH CARE PROVIDER),** release to KAP Endocrine, PLLC, the above-named patient's medical records, including laboratory results, radiologic testing results, medications, hospitalization information, office notes, and treatment plans. I understand that this authorization will expire when this request is fulfilled and that it may be revoked at any time in writing. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient or third parties and no longer protected by the HIPAA privacy rule.

Specific records being requested: __________________________________________

______________________________________________________________________

I acknowledge that my records may include sensitive material. Therefore, I request that you include the following records, if any (initial by categories to be included in records provided):

___ Substance Abuse ___AIDS/HIV/STDs ___Psychological/Psychiatric Conditions
___ Genetic Testing

**Please send the requested information to:**

KAP Endocrine, PLLC
400 Sugartree Lane, Suite 520
Franklin, Tennessee 37064
Phone: 615-857-5110
Fax: 615-205-4206

______________________________________________________ ____________

Signature of Patient or Legal Guardian Date

______________________________________________________

Printed name

Relationship to Patient: _____________________________________________________