# ENDOCRINE ASSOCIATES OF THE QUAD CITIES

612 35th AVENUE
MOLINE, IL 61265
PHONE 309-788-0014
FAX 360-462-6344

1989 SPRUCE HILLS DRIVE
BETTENDORF, IOWA 52722
PHONE 563-293-3131
FAX 360-462-6344

**I, __________________________________________, hereby authorize ________________________________**
**(Name of patient or authorized agent) (Name of physician)**

**to release to: ________________________________________________________________________________**
**(Name of health care facility, physician, agent, etc.)**

**_____________________________________________________________________________**
**(Street address, city, state and zip code)**

**the following information contained in the patient record of __________________________________________**
**(Patient's name)**

**born ________________, residing at _______________________________________________________________**
**(Birth date) (Street address, city, state and zip code)**

**( ) General Medical Information**

**( ) Lab & X-ray Data**

**( ) Reports From Other Facilities or Physicians**

**( ) Mental Health Treatment**

**( ) Drug or Alcohol Abuse Treatment**

**( ) HIV Related Information**

**( ) Other _________________________________**

**I understand this authorization is effective for one year from the date on which it was signed and that I may revoke this authorization for any reason by giving written notice. I understand I have the right to inspect the information to be disclosed upon proper notification. I understand that if the recipient of this information is not a health plan or provider, the released information may no longer be protected by federal privacy regulations.**

**______________________________________________________________ ___________________**
**(Signature of patient or authorized agent and relationship if not patient) (Date)**

**______________________________________________________________ ___________________**
**(Witness) (Date)**