THE SUGAR DOCTORS, LLC
ENDOCRINE • DIABETES • THYROID

Authorization to Use and Disclose Protected Health Information

Patient Name:			MRN (office use only):
Current Address:	City:	State:	Zip Code:
Phone Number:			Date of Birth: / /

This authorization is to release the protected health information to:

The Sugar Doctors, LLC / John A. Purcell, MD
8613 S. Old Kings Road, # 301
Jacksonville, FL 32217

Phone: (904) 280-6650
Fax: 1-844-777-1833
Email: info@thesugardoctors.com

Deliver by: ❑ In person ❑ Mail ❑ Fax ❑ Email

This authorization is to release the protected health information from:

Facility Name/Provider:

Phone Number:
Fax Number:

The purpose of this disclosure is: continuation of care

Dates of services requested:

Release the following information:

Patient Health Information

- ❑ Discharge Summary
- ❑ History & Physical
- ❑ Consultation(s)
- ❑ Operative Report(s)
- ❑ Progress Notes
- ❑ Pathology report(s)
- ❑ Radiology report(s)
- ❑ Lab report(s)
- ❑ Cardiology report(s)
- ❑ Treatment Plan(s)
- ❑ Diabetes/Nutritional Education
- ❑ Emergency Record(s)
- ❑ Other Protective Health Information as specified: ____

This Authorization will remain in effect:

❑ From the date of this Authorization or until the following event occurs: ______________________________

❑ Unless otherwise noted above this authorization will remain in effect 365 days from the date signed

I do not have to sign this authorization form in order to receive treatment from The Sugar Doctors, LLC/ John A.Purcell, MD. In fact, I have the right to refuse to sign this authorization form. When my information is used, received, or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA Privacy rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at: 8613 S. Old Kings Rd #301, Jacksonville, FL 32217. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information.

Signed By: ______________________________ ________________ Relationship to Patient: ______________________
Signature of patient or legal guardian

____ Date: _____________________________________
Print name of patient or legal guardian