endocrine kids
teamworkcommunicationtrust · jacalyn bishop, md, faap

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**PATIENT**

Name: _____ Birthdate: _____

Address: _____

City/State/Zip: _____

Social Security No. _____

I hereby authorize _____
to disclose my protected health information, as indicated below, to:

**Jacalyn M. Bishop, M.D., P.C.**
25500 Meadowbrook Rd. Suite 130
Novi, MI 48375
P 248-347-3344
F 248-305-6845

The information to be disclosed is (check appropriate box):

- ☐ Entire Record
- ☐ Only endocrinology related notes, results and information, including growth charts and bone age x-ray results
- ☐ Only information related to (specify): _____
- ☐ Only the period of events from _____ to _____
- ☐ Other (specify): _____

I understand that I may revoke this authorization at any time by submitting a written revocation to Jacalyn M. Bishop, M.D., P.C., except to the extent that action has already been taken in reliance on this authorization.

If I have not revoked this authorization in writing this authorization will expire one hundred twenty (120) days from the date signed.

Dated: _____

Signature: _____
Printed name: _____
Patient's name: _____