Adonai Diabetes and Endocrinology Center, Inc.
Office: 907-357-2332 Fax: 907-357-2344

1. Patient Name:_____
(Last) (First) (MI)

Maiden/former name: _____
(Last) (First) (MI)

Street Address: _____

City, State, Zip: _____

Birth Date: ___/___/_____ Soc. Sec. No.: _____-_____-_____

Home Phone: (_____)_____ Work Phone: (_____)_____

2. I, Authorize:

_____

_____

_____

_____

Release to:

Samuel L. Abbate MD, CDE

3331 E. Meridian Park Loop

Wasilla, AK 99654

3. ☐ Information to be faxed as soon as possible ☐ Picked up Date:_____

4. Information to be released:

☐ All available information ☐ Specific date range: _____

☐ Clinic notes ☐ Radiology reports ☐ Laboratory reports

☐ Hospital record, complete (Including: laboratory, radiology, pathology, consultations and surgical reports)

5. Purpose of disclosure: Medical assessment and treatment.

6. The information may be communicated in the following manner: ☐ Oral ☐ Written

7. This authorization shall be in effect for 12 months following the date of signature.

8. I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that action has already been taken in reliance on it and that in any event this consent expires automatically as described above. I also understand the Chemical Dependency client's/patient's records are protected by the Federal Law (42CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations.

9. I understand that information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

10. **A photocopy is as valid as the original.**

Signature of Patient or Guardian:

_____ Date_____

Print Name: _____

Relationship to patient if unable to sign_____

Witness _____

Print Name: _____