

# THE ENDOCRINE GROUP, LLP

ENDOCRINOLOGY

METABOLISM

DIABETES

METABOLIC BONE DISEASE

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## Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or the practice's administrative and clinical staff to use and/or disclose health information about me as described below.

1. Description of the information to be used or disclosed: **Laboratory, radiological or other test results.**
2. Name and address of the individual or entity authorized to receive information:  
**List applicable patient phone number(s) here:** \_\_\_\_\_  
**Laboratory, radiological and other test results will be communicated to the patient by telephone. If the patient is not available to take the practice's call, a message containing the patient's laboratory, radiological or other test results may be left on the patient's answering machine or voice mail. Answering machine or voice mail messages may be played or overheard by other members of the family or any other individual who has access to the patient's answering machine or voice mail.**
3. This protected health information is being used or disclosed for the following purposes:  
 At the request of the patient  
 At the request of the referring provider  
 Other (briefly describe) \_\_\_\_\_
4. This authorization shall be in force and effect until \_\_\_\_\_, at which time this authorization to use or disclose the described health information expires.
5. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the practice's Privacy Contact Privacy Officer at The Endocrine Group, LLP, 1365 Washington Avenue, Suite 300, Albany, New York 12206. I understand that a revocation is not effective to the extent that my physician has relied on this authorization prior to receiving notice of revocation or my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
6. I understand that if the person or entity that receives the health information described above is not health care provider, health plan or health care clearinghouse covered by the federal privacy regulations, the information described above may be redisclosed by the recipient and no longer be protected by the privacy regulations.
7. **I understand that it is my responsibility to notify the practice if my telephone number changes. I understand that health information left by my physician on my answering machine or voice mail may be overheard by family members or other individuals. I also understand that while unlikely, it is possible that my health information may be accidentally left on an answering machine that does not belong to me.**
8. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

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Signature of Patient or Personal Representative

Date

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Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

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I do not want the above left on my answering machine.

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Signature of Patient or Personal Representative

Date

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Print Name of Patient or Personal Representative

Description of Personal Representative's Authority