STONESIFER ENDOCRINE CARE
LARRY STONESIFER, M.D., F.A.C.P., F.A.C.P.
MARCIA MILLER, A.R.N.P.
MARJORIE SLADEK, A.R.N.P.
Internal Medicine/ Endocrinology & Metabolism
34509 9th Ave. S. Suite #200 Federal Way, WA 98003
Phone: (253) 927-4777 Fax: (253) 927-6580

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____ Phone No.: (____)_____
(Please Print)

I do hereby, authorize _____
Name of Physician, Facility or Person

Located at _____
Street City State Zip

To release protected health information, contained in the medical record of the above-named patient to Stonesifer Endocrine Care Clinician:

___ Dr. Larry Stonesifer

___ Marcia Miller, A.R.N.P

___ Marjorie Sladek, A.R.N.P

RECORDS SENT TO:
Stonesifer Endocrine Care
34509 9th Ave. S. Suite #200
Federal Way, WA 98003
Phone: (253) 927-4777 Fax (253) 927-6580

MEDICAL RECORDS TO BE RELEASED:

___ All healthcare information including records of testing and/or treatment for drug & alcohol dependence, psychiatric or mental health disorders, sexually transmitted disease including AIDS, or transsexualism.

___ I do **NOT** consent to the release of the following:
- ___ Sexually Transmitted Disease ___ HIV Testing results or Treatment
- ___ Substance Abuse (Alcohol/Drug)
- ___ Transsexualism ___ Mental Health or Psychiatric Disorders

___ Other: _____

Purpose for which disclosure is being made: (please check one of the following.)

___ Attorney ___ Insurance ___ Doctor ___ Personal

I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, and enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the privacy notice to our patients. I understand that once the above named facility discloses health information, the person or organization that received it may re-disclose it, at which time it may no longer be protected under privacy laws. If you desire a copy of this authorization, please notify a representative of the medical records department upon completion of this form

SIGNATURE: _____ DATE: _____

Please provide documents to prove authority to sign on behalf of the patient. This authorization will expire 90 days from the date signed. Please be aware that medical record copy fees may apply and contacting your former healthcare provider for specific medical record processing details is recommended.