DIABETES AND ENDOCRINE WELLNESS CENTER, LLC **Charmaine Blake Woode, MD**
Dwain E. Woode, MD
One Hospital Drive SW, Suite 300 Huntsville, AL 35801 Phone: 256-881-2700 Fax: 256-429-9109

PERSONAL AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security Number: _____

I request and authorize Diabetes and Endocrine Wellness Center, LLC to **verbally** release my healthcare information to the person(s) indicated below:

Name: _____Relationship:_____Address:_____

Name: _____Relationship:_____Address:_____

Name: _____Relationship:_____Address:_____

AUTHORIZATION TO RELEASE WRITTEN MEDICAL RECORDS TO PHYSICIAN/INDIVIDUAL

Physician/Individual Name: _____

Medical Practice/Company Name: _____

Address: _____City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Reason for Request: _____

Please Release:

___All Records

___Specific Information or Dates: _____

___Letter Containing the Following Information: _____

_____

___ ***From*** Diabetes & Endocrine Wellness Center, LLC to the practice /individual listed above.

___ ***To*** Diabetes & Endocrine Wellness Center, LLC from the practice /individual listed above.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Relationship: _____ Date: _____
(Patient under the age of 18)

Witness: _____ Date: _____

I understand that this authorization is voluntary and it expires 12 months after the date signed. I may choose to revoke this consent at any time in writing.