

EXHIBIT 6

Southeastern Endocrine & Diabetes, P.C.

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

By signing this authorization, I authorize _____ to use and/or disclose
certain protected health information (PHI) about me to _____

(Name, address and phone/fax of entity to receive this information)

This authorization permits _____ to use and/or disclose the following
identifiable health information (specifically describe the information to be used or disclosed, such as date(s) of
service, type of services, level of detail to be released, origin of information, etc.): _____

This authorization will expire on _____ (please allow at least 1 week)

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by
the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this
authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

Signed by: _____
SIGNATURE of Patient or Legal Guardian

Relationship to Patient

Patient Name (if different from above)

Date

PRINT Patient Name or Legal Guardian

PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION