Diabetes & Endocrinology Specialists, Inc.

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CONSENT FORM

Patient: _____

Physician: _____

In connection with the medical services that I am receiving from the above-named physician or physician group, I hereby authorize the above-named physician and/or group to disclose any/or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

A. Any third party payor covering the medical services of the patient;
B. Other health care professionals and institutions involved in the delivery of health care to the patient;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
E. Pharmacies;
F. Other parties as otherwise required by law; and
G. The site may use information protected by HIPAA for certain research activities without patient authorization. Research information is for office use only and will not be released without written authorization.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given:

Special Restrictions: _____
_____

This consent is valid from the date executed until revoked in writing by the patient.

Signed: _____

Date: _____

Witness: _____