AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Diabetes Management Associates

Patient Name: _____ Birth Date: _____ Last 4 digits of S.S#: _____

Address: _____ Phone #: _____

I authorize the Diabetes Management Associates to:

☐ **Release** my health information to: DMA 401 1st Ave. Mt. Pleasant TN, 38474
Name and Address

☐ **Obtain** my health information from: _____
Name and Address

PURPOSE: ☐ Further Care ☐ Legal ☐ Insurance ☐ Payment and Billing ☐ Personal Use

Date(s) of treatment to be released: _____ to _____

Information to be released:

☐ Office notes from last visit
☐ Labs since LAST office visit
☐ Download of meter or pump from last visit
☐ Other _____
☐ Insulin scale
☐ Educators last note
☐ Correspondence from past 6 months

I understand that:

- I do not have to sign this authorization in order to receive treatment, payment or eligibility of benefits
- The release of my information may include information regarding diagnosis and/or treatment from other facilities or providers
- This authorization will remain in effect for 90 days after the date recorded below
- This authorization can be taken back (revoked) at any time with a written request to this office
- Revoking the authorization stops further release but cannot undo any release of information that may have already occurred.
- Once the information is released because of this request, it could be released by the recipient and the information may not be protected by Federal privacy regulations.
- My records may include information regarding the diagnosis or treatment for alcohol and/or drug use; psychiatric or mental illnesses; and/or sexually transmitted diseases (STDs), as well as AIDS or HIV information AND that I can limit the release of this type of information.
- My signature below authorizes Diabetes Management Associates to furnish or obtain the information specified above even though the confidentiality of the information may be protected by Federal and State law and regulations.
- Diabetes Management Associates is hereby released and discharged of any liability, and I will hold Diabetes Management Associates harmless for complying with this authorization.

_____ _____ _____

Print Name of Patient or Authorized Individual | Signature of Patient or Authorized Individual | Date and Time

_____ Photo ID was provided: ☐ Yes ☐ No – if No,

Relationship to patient and/or description of authority to act for the patient | specify form of patient identification _____