DIABETES ASSOCIATES MEDICAL GROUP

Disclosure of Medical Records Consent Form

Patient: ____

Physician: ____

I have received a copy of the offices' Notice of Privacy Policy.

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; and

F. Other parties as otherwise required by law.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above.

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

Signed: __________________________________Date: __________________________