Arizona Diabetes & Endocrinology, PLC (AZDE) HIPAA and Release of PHI

Last Name _____First Name_____Middle Initial_____ DOB:_____

☐ I Do ☐ I Do NOT give my permission for AZDNE to leave messages regarding my lab results, treatment, diagnosis, appointments, billing/payments, and any other pertinent information regarding my care at the following number(s):

Mobile Number_____Home Number_____

Do you consent to receive automated **email** messages from our office? Yes / No

Do you consent to receive automated **phone** messages from our office? Yes / No

Do you consent to receive automated **text** messages from our office? Yes / No

By signing below, I acknowledge that I have received the Notice of Privacy Practices of AZDNE which explains its legal duties and privacy practices with respect to my Protected Health Information (PHI). I understand that I may refuse to sign this acknowledgement. I authorize AZDNE to disclose my PHI as specified below to the individuals listed below.

Name_____Relationship_____Phone_____
Information to be released (circle): ALL / Treatment / Diagnosis / Appointment / Billing / Other_____

Name_____Relationship_____Phone_____

Information to be released (circle): ALL / Treatment / Diagnosis / Appointment / Billing / Other_____

Name_____Relationship_____Phone_____

Information to be released (circle): ALL / Treatment / Diagnosis / Appointment / Billing / Other_____

The above authorizations shall remain in effect until I provide Arizona Diabetes & Endocrinology, PLC with written revocation. I understand I cannot revoke this authorization retroactively for information already released. I understand when Arizona Diabetes & Endocrinology, PLC discloses PHI pursuant to this authorization, they can no longer guarantee confidentiality or prevent re-disclosure and the information may no longer be protected by federal privacy rules. I understand by signing this authorization I agree to allow Arizona Diabetes & Endocrinology, PLC and its staff to disclose the protected health information to the above stated person(s) and/or entity.

Patient or legally authorized representative Signature_____ Date _____

Printed name if signed on behalf of the patient_____Relationship_____

FOR OFFICE USE ONLY

I, _____(Employee Name), made a good faith effort to obtain written acknowledgement of the receipt of the Notice of Privacy Practices of AZDNE for the above-named patient. I was unable to obtain written acknowledgement due to the following reason:

☐ Individual refused to sign ☐ Communication barrier ☐ An emergency situation ☐ Other_____