Lenita Hanson MD PA, Inc (LHMDPA)/ Hanson Clinical Research Center /Living Smart Diabetes SM Program
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AUTHORIZATION FOR USE / DISCLOSURE OF HEALTH INFORMATION

Fax medical record requests to: Fax: 941-206-0048

Patient Name: _____ **Date of Birth:** _____

By signing this form, I understand that I am authorizing the use / disclosure of health information about me as defined under 45 CFR 164.501, the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 as described below.

❑ Obtain / Request records from OR ❑ Send / Release records to:

Name/Facility: _____

Address: _____

Phone: _____ Fax: _____

Purpose: ❑Continuity of Care ❑Transferring care ❑Personal use _____

Information to be disclosed: I authorize the release of the below checked items:

❑ Last hospitalization medical records ❑Medical records for the past _____ years

❑ Specific records: _____

❑ Diabetes class referral form ❑ authorization for CPT G0109 and G0108 ❑ Last Provider note and Glucose log, meter, CGM or labs documenting two fasting blood sugars at 126 or above *(diagnosis confirmation)*

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV results or AIDS information _____ **(initial)**

Term: I understand that this Authorization will remain in effect until the Provider fulfills this request which may be extended beyond my death if I am a clinical trial participant.

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at LHMDPA. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to LHMDPA Office of Compliance at the address listed above. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation. I understand that I may see and obtain a copy of the information released for a reasonable copy fee.

Questions: I may contact the LHMDPA Officer of Compliance for answers to my questions about the privacy of my health information at telephone (941) 624-4800. An electronic or facsimile copy of this document is as good as the original.

I have read the above and authorize the disclosure of the protected health information as stated.

Patient Signature: _____ **Date:** _____

Legal Representative Relationship: _____

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*OFFICE USE ONLY: Staff to date and initial below HCRC Study Protocol#*_____

1st attempt: _____ *2nd attempt* _____ *3rd attempt* _____

CONFIDENTIAL: To recipient: This is confidential and privileged information. Any further dissemination of or reproduction of this information without expressed consent of patient is prohibited by law.