KATY DIABETES AND ENDOCRINOLOGY

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PATIENT CONSENT FOR PHYSICIAN TO USE OR DISCLOSE HEALTH CARE

Patient's Name:_____

Date of Birth: _____

To give consent to disclose health care information to someone other than the patient, please write their name below.

Name:_____

Date of Birth: _____

I understand that my health information is private and confidential. I understand that Katy Diabetes and Endocrinology works very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that Katy Diabetes and Endocrinology may use and disclose my personal health information to help provide healthcare to me, to handle billing and payment, and to take care of other health operations.

Under the terms of this consent, I can ask Katy Diabetes and Endocrinology to restrict how my personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Katy Diabetes and Endocrinology does not have to agree to my request. If they do agree to my request, I understand that agreed limits will be followed.

I understand that I have the right to cancel this consent in writing at any time. If I do cancel the consent, I understand that Katy Diabetes and Endocrinology may have already used or disclosed information about me and canceling this consent would not affect the information already used or disclosed.

I may cancel this consent at any time by doing the following:

Writing, signing, and dating a letter to Katy Diabetes and Endocrinology that says I want to revoke my consent to authorize the use and disclosure of my personal health information for treatment, payment and health care options.

My signature below indicates that I agree to the policies outlined by this document and all statements therein.

Patient Signature:_____ Date _____

Printed Name/Relationship:_____