Diabetes Education and Wellness
1910 Route 35, Oakhurst NJ 07755
Phone: 732-676-8381 Fax: 732-876-3059

HIPAA AUTHORIZATION FORM

Patient's Full Name _____ **Medical Record Number** _____

Address _____ **Patient's Date of Birth** _____

City, State Zip Code _____ **Patient's Telephone Number** _____

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is **authorized to use or disclose information abo**ut me:
   _____***Diabetes Education and Wellness***_____

   The following **person (or Facility) may receive** disclosure of protected health information about me:

   His/her/its Name and Relationship: _____

   Address: _____

   Telephone Number: _____

2. The specific information that should be disclosed is (please give dates of service if possible):

   All or Please specify: _____

   _____

   _____

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
4. I may revoke this authorization by notifying **Diabetes Education and Wellness** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
5. My purpose/use of the information is for _____

_____	_____	_____
Signature of Individual* (The person (pt.) about whom the information relates)	**Date of Individual's Signature**	**Date of Birth**

OR, if applicable –

_____	_____	_____
Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

BEST WAY TO COMMUNICATE WITH PATIENT

Leave message YES NO	**Leave message YES NO**	**YES NO**
Cell phone:	**Home Phone:**	**Family:**

EMAIL:_____