AUTHORIZATION FOR RELEASE/ACQUISITION OF PATIENT INFORMATION

The undersigned hereby authorizes the ____
Local Health Department Name

____
Address of Local Health Department

To release to/or procure from ____
Name of Healthcare Provider who helps with diabetes care

____
Address of Healthcare Provider

Information from the patient/clinic record of:

Name: ____ Date of Birth: _________________

The following information is requested to be released for the purpose of outcomes reporting for the diabetes self-management education & support program:

Hemoglobin A1c and Blood Pressure

I understand that this authorization will expire 12 months from the date signed. I also understand that I may revoke this authorization at any time. I understand that my information may not be protected from re-disclosure by the requester of the information. I also understand my refusal to sign this authorization will not affect my ability to obtain treatment, payment for services or eligibility for benefits. If a service is requested by a party other than the patient for the purpose of creating health information, refusal to sign this authorization may result in the service request being denied. I understand I can cancel this authorization and to do so I must send a written request to the Local Health Department Agency specifically authorized above. I understand I can obtain a copy of my health care data and to do so I must submit a written request to the Local Health Department Agency specifically authorized above.

____
Signature of Client/Patient, Parent or Legal Guardian **Date**

____
Relationship (if signature is not patient/client)

____
Signature of Witness **Date**

(Only required when client/patient, parent or legal guardian signs by mark)

Rev (08/2020)