DIABETES CARE CENTER

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Diplomates of the American Board of Internal Medicine
Diplomates of the American Board of Endocrinology, Diabetes and Metabolism

PATIENT PRIVACY QUESTIONNAIRE

I authorize discussion and release of my general medical condition and diagnosis (including but not limited to treatment, payment, and health care operations) to:

1. Name: _____Relationship: _____

   Address: _____

   Telephone:_____DOB: _____

2. Name: _____Relationship: _____

   Address: _____

   Telephone:_____DOB: _____

3. Name: _____Relationship: _____

   Address: _____

   Telephone:_____DOB: _____

This authorization remains in effect until I revoke it in writing.

Patient Name: _____
(Print)

Patient Signature: _____

Date: _____ Date of Birth: _____

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