Saad Sakkal, MD – Medical Director

HIPAA RELEASE OF INFORMATION

Patient Name: ________________________ Date of Birth: _____________ Confidential Next of Kin: _________________________

I hereby authorize the release of my medical records, medications to the physicians/staff at the Metabolic Care Center.
It is frequently necessary for personnel at the Metabolic Care Center to communicate lab results, radiology results, instructions, information about treatment, and other items of Protected Health information with me or confident next of kin. In the event that our staff is not able to speak with you (the patient) directly, please give us instructions regarding communication with you.
WE WILL NOT GIVE OUT ANY INFORMATION UNLESS YOU INDICATE BELOW:

Signature: ____ Date:___________________________________

Consent to release information to patient:

Consent to call phone or fax information to the following numbers upon patient request: 1) (________) _____________________

2) (________) _____________________

Messages may be left on **my voicemail** (For lab results, treatment, etc.) ____No ____Yes @ (________) ___________________
Phone number (Please write)

Online Information Exchange is also possible and allowed for patients who have a user name and password to MCC portal: ____Yes

Messages may be left with the following persons:

Name: ______________________________________ Relationship: __________________ Phone: (________) __________________

Name: ______________________________________ Relationship: __________________ Phone: (________) __________________

Consent to release information to physicians involved with my healthcare:

Physician's name: ____________________________________ Practice name: ____

Physician's name: ____________________________________ Practice name: ____

Consent to release information to my pharmacy if asked for treatment or payment purposes:

Pharmacy name: _____________________________________ Phone: (________) ___________________

Diabetic Supply Company Used (Testing & Pump Supplies): ____

Note: 1) by law, Metabolic Care Center cannot use or share my health information without my permission, except by ways listed in the Metabolic Care Center notice of private practices. 2) I can cancel this permission/request at any time. I must cancel in writing and will receive written confirmation from Metabolic Care Center of their receipt of my request. I cannot cancel the sharing of information already given as a result of this permission. 3) There may be a charge to make copies of my medical records. 4) I understand and acknowledge that this may include treatment for physical and mental health, alcohol/drug abuse and/or HIV/AIDS test results or diagnosis. If the person signing this permission is the patient's legal guardian, healthcare agent, attorney, or administrator/executor of the patient's estate appropriate documentation of legal authority must be provided before records may be released.

Signature: ____ Date:___________________________________