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CONSENT TO DISCLOSE MEDICAL INFORMATION

Name: _____ D.O.B. _____

Please check one of the following:

☐ I give permission to the employees of Central Florida Endocrine & Diabetes Consultants, P.A. to disclose my Protected Health Information to me and the following individual (s).

Name: _____ Relation _____

Name: _____ Relation _____

Name: _____ Relation _____

Name: _____ Relation _____

Name: _____ Relation _____

Name: _____ Relation _____

☐ I request that all my Protected Health Information be disclosed ONLY to me and no other individual(s).

I understand that I may revoke or change this consent at any time by filling out another consent form to replace this one. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent to disclose medical information shall be valid for a period of one calendar year unless otherwise expressly stated.

_____ _____

Patient Name (Print) Date

_____

Patient or Guarantor (Signature)