Florida Health Care Coalition Diabetes Program

Physician Release Form

(HIPAA Release Form)

Program phone: 321-316-2250

Program email: DiabetesProject@FLHCC.ORG

Please note that you will have until Friday, March 4, 2016 to enroll in the research portion of the program. The enrollment will be closed off at midnight on Friday, March 4, 2016.

Release of Information

I, _____hereby authorize_____ (name of treating physician) and its affiliates, its employees and agents, to release to Florida Health Care Coalition Diabetes Program staff my Hemoglobin A1c (HbA1c) screening results for the purpose of the Diabetes Program. This Release of Information will remain in effect until terminated by me in writing. The HbA1c results will be requested at the following intervals: at enrollment before switching to pens, 6 months and, 12 months after switching to pens.

I understand that I have a right to revoke this authorization by providing written notice to the program staff at the Florida Health Care Coalition.

I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility to participate in the diabetes program.

Name of Participant: _____

Signature of Participant: _____

Date: _____

Treating Physician Phone Number: _____