**Botts Diabetes and Endocrinology**

**HIPAA/Permission Form**

The Health Insurance Portability and Accountability Act (HIPAA) requires Botts Diabetes and Endocrinology (BDE) to notify patients regarding how their Protected Health Information (PHI) is handled. Our HIPAA policy is posted in the lobby. You have the right to review the HIPAA policy and you may request a copy of the policy.

With your permission, we may disclose your PHI to a family member, close friend or any other person that you identify. If the individual is not listed, we will not discuss any information regarding you or your PHI. This does not apply to information sent to an entity for the purpose of payment or treatment.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize BDE to release any personal information relating to my health care

 TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_

 TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_

I have reviewed the HIPAA Notice of Privacy Practices for BDE. I hereby acknowledge that I am familiar with and understand the terms of this policy. I understand it is my responsibility to notify you of any changes in writing.

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Patient/Guardian Signature Relationship to Patient Date

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**Prescription/Sample Medication Permission Form**

With your permission, we may release prescriptions and/or sample medications to a family member, close friend, or any other person that you identify. If the individual is not listed, we will not release the prescription and/or sample medication.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize BDE to release prescription/sample medication for my health care to:

 TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_

 TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_

I hereby acknowledge that I am familiar with and understand the terms of this policy. I understand it is my responsibility to notify you of any changes in writing.

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Patient/Guardian Signature Relationship to Patient Date

Revised 01-01-2021/jj