

Medication Refills

Prescription refills must be called or faxed into our office by your pharmacy, 72 hours in advance. If you participate with a mail away pharmacy, your new prescription will be provided to you directly. Please allow adequate time for the new prescription to reach you. PLEASE MAKE SURE THAT ALL MEDS ARE REFILLED AT THE TIME OF THE VISIT. PLEASE KEEP AN UPDATED LIST OF YOUR MEDICATIONS AT ALL VISITS.

Please sign that you have read and understand the above.

Patient Signature _____ Date _____

Authorization of Release to Others

(Please fill out one)

I am hereby giving permission to Endocrine, Diabetes, and Osteoporosis Clinic, to leave medical information on my answering machine at my residence/ with family members listed below when I am not available. This information could be regarding the results of laboratory work, medication changes, recommendations, or other evaluations.

Family/Individual to release to: _____

I, _____ am hereby stating that Endocrine, Diabetes, and Osteoporosis Clinic, may only release my medical information to me and I should be contacted at all times at home/work/either.

I further understand that I may revoke this authorization at any time. This must be in writing to the healthcare provider with an effective date and on retroactive dates will be accepted. Please initial. _____

Consent Agreement and Privacy Notice

Though it is not required with HIPAA (Health Insurance Portability and Accountability Act of 1996), it is our policy to obtain a signed consent from all of our patients as it relates to the use and disclosure of their Individually Identifiable Health Information (IIHI). This is to ensure the accurate and timely payments for services rendered by our office. The law requires we inform you of our policy regarding the protection of your IIHI through our **Privacy Notice**, which we will provide for you. In the notice you will find full explanation of how our office will accomplish this. Thank you for your continued confidence in our practice and supporting our new requirements.

The following statement allows us the necessary latitude to work within the new requirements.

I, _____, have been presented with a Privacy Notice explaining my rights regarding my IIHI (individually identifiable health information). I consent to the use and disclosure of my IIHI for purposes of treatment, payment or other health care operations. Additional uses of my IIHI will require an authorization from me for the specific intention of disclosure.

Patient: _____ Date: _____