Marina Diabetes Center NOTICE OF PRIVACY PRACTICES

RELEASE OF INFORMATION

I acknowledge that there are instances when **Michael Robinson, MD** must release information concerning my care, including copies of my medical records, to certain individuals or entities that are involved in my care, payment for my care, and other activities related to my care. These include, but are not limited to, disclosures to:

1. Any health professionals involved in my care for the purpose of facilitating the continuity of my medical care;
2. Any person or entity responsible for, or any person or entity acting as agent for the party responsible for payment, including third party payors, self-insurers, worker's compensation carriers and governmental agencies, payment for the medical care rendered to me at this practice by their employees or any person providing services at this practice or any affiliate;
3. Any federal, state, or other governmental or quasi-governmental agencies or their parties as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs;
4. Any person or entity participating in quality studies, utilization review or similar studies of the care rendered by this practice and its affiliates and/or their physicians; and
5. Any continuing-care, residential, or long-term care facility, or home health agency for the purposes of providing services for my care.

When providing information to me, information can be transmitted to me by any or all of the following means (initial all that apply):

_____ **Telephone messages on an answering machine**

_____ **Messages to the following family members or friends:**_____

_____ **E-mail to the following address:**_____

Notwithstanding the preceding paragraph, in the event you cannot reach me, you may share my medical information with _____ who is my _____.

I acknowledge that my medical information may include information relative to alcohol abuse, drug abuse, psychological or psychiatric conditions, Human Immunodeficiency Virus (HIV) and/or Acquired Immunodeficiency Syndrome (AIDS). In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I had the opportunity to place special restrictions upon the consent hereby given:
Special restrictions:
_____

This consent is valid from the date executed until revoked in writing by the patient. By initialing below, I acknowledge that I have read this form and understand its contents fully and have received a copy of the NOTICE OF PRIVACY PRACTICES and agree to obey the rules and regulations of this practice. PATIENT INITIALS: _____

The undersigned is the patient, the patient's legal representative, or is authorized by the patient to execute this form and accept its terms.

SIGNATURE OF PATIENT:_____ **DATE:**_____