RALEIGH ENDOCRINE ASSOCIATES

ENDOCRINOLOGY DIABETES & METABOLISM

DENIS I. BECKER, M.D., P.A.C.E. ● ELIZABETH H. HOLT, M.D., P.A.C.E. ● COREY D. BERLIN, M.D.

GLENN M. STALL, M.D., ● SHAWNEE D. WEIR, M.D., P.A.C.E. ● JOSEPH RAND, M.D.

ANGELA GLASS, M.S.N., F.N.P.-C., ● WILBUR BARDON, P.A.-C ● LISA HILL, P.A.-C

HIPAA- PRIVACY CONSENT FORM

For Use of Disclosure of Private Health Information

- Trust is the foundation of a doctor/patient relationship.
- The information that you provide us will be kept in the strictest of confidence.
- While protecting your privacy is extremely important to us, there may be certain situations that may require us to use or disclose your healthcare information:
    1. It may be necessary to use or disclose your private health information to another healthcare provider or hospital when referred to them for the diagnosis, assessment or treatment of your health.
    2. It may be necessary to use or disclose your private health information and billing records to another party if they are responsible for the payment of your services.
    3. It may be necessary to use or disclose your private health information within our practice for quality control and operational purposes.

Authorization for Appointment Reminders and Health Care Information

We will be using your health insurance information for payment. A claim may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures performed and/or supplies used.

There may be times when the doctor or the staff of Raleigh Endocrine Associates may need to use your private health information (such as your name, address and phone number) in order to contact you with regard to appointment reminders, requested information about alternative treatment, or other health related information. If you are not at home to receive this information, please check one of the following:

☐ **OKAY TO LEAVE MESSAGE.**

☐ **NOT OKAY TO LEAVE MESSAGE.**

If you would like to have your personal health information disclosed to anyone other than yourself, please fill in the following information.

_____ _____

ADDITIONAL FAMILY MEMBER(S) **ADDITIONAL FAMILY MEMBER(S)**

I have read this consent form and agree to its term. I also acknowledge that once I sign this consent form, at my request, I will receive a copy for my record.

_____ _____

PRINT NAME WITNESS

_____ _____

PATIENT SIGNATURE **DATE**

2709 BLUE RIDGE ROAD ● SUITE 320 ● RALEIGH, NC 27607
PHONE: (919) 876-7692 FAX: (919) 954-3365