FOR OFFICE USE ONLY:

Patient Name _____
MRN _____

OPTIONAL AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO OTHERS

I authorize Diabetes and Endocrinology Clinical Consultants of Texas to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to Diabetes and Endocrinology Clinical Consultants of Texas of changes or updates. I also authorize Diabetes and Endocrinology Clinical Consultants of Texas to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my insurance or test results.

❑ **Only Release Information to Patient**
If *no* answer, may we leave a message on your: Home Phone ❑ Y ❑ N Work ❑ Y ❑ N Mobile ❑ Y ❑ N

Name _____ **Relationship to Patient** _____

Home Phone _____ May We Leave a Message? ❑ Y ❑ N Mobile _____ May We Leave a Message? ❑ Y ❑ N

You may release the information regarding the following services to the person named above: ❑ **Appointments** ❑ **Billing** ❑ **Medical Care**

Name _____ **Relationship to Patient** _____

Home Phone _____ May We Leave a Message? ❑ Y ❑ N Mobile _____ May We Leave a Message? ❑ Y ❑ N

You may release the information regarding the following services to the person named above: ❑ **Appointments** ❑ **Billing** ❑ **Medical Care**

If you wish to receive your health information by email, the information will be sent via encrypted email unless you expressly designate otherwise below. Sending health information by unencrypted email may pose some risk that the health information in the unencrypted email could be read by a third party over the internet.

Initials _____

FINANCIALLY RESPONSIBLE PARTY - GUARANTOR

❑ **Same as Patient Information (If different, please complete section below)**

Name: First _____ MI _____ Last _____ DOB _____

Relationship (Please circle): Spouse Father Mother Other (Please Specify) _____

Address: _____ Apt# _____ City _____ St _____ Zip _____

Phone: Home _____ Cell _____ Work _____

Employer Name _____ **Employment Status:** ❑ Student ❑ Part Time ❑ Full Time ❑ Retired ❑ Disabled ❑ Unemployed

INSURANCE INFORMATION

PRIMARY INSURANCE _____ **ID** _____ **GRP#** _____

Subscriber Name _____ **Sex:** ❑ M ❑ F Patient Relationship to Subscriber _____

Subscriber DOB _____ **Phone:** Home _____ Cell _____ Work _____

Employer Name _____ **Employment Status:** ❑ Student ❑ Part Time ❑ Full Time ❑ Retired ❑ Disabled ❑ Unemployed

SECONDARY INSURANCE _____ **ID** _____ **GRP#** _____

Subscriber Name _____ **Sex:** ❑ M ❑ F Patient Relationship to Subscriber _____

Subscriber DOB _____ **Phone:** Home _____ Cell _____ Work _____

Employer Name _____ **Employment Status:** ❑ Student ❑ Part Time ❑ Full Time ❑ Retired ❑ Disabled ❑ Unemployed