PALM BEACH DIABETES & ENDOCRINE SPECIALISTS, P.A.

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Designation for Release of Medical Information to a Family Member, Friend or Legal Representative

Introduction:

It is the physicians' responsibility to ensure that the physician-patient relationship is confidential. The Privacy Statement of Palm Beach Diabetes & Endocrine Specialists, P.A. ("PBDES") is the basis for how we treat your Protected Health Information. HIPAA allows physicians to use their professional judgment on disclosing certain PHI to family, friends, etc. without an authorization. This form is an aide to the physicians in making a determination on disclosing such information. Drs. Kaye, Horowitz, Pepper, Patel, Steinsapir, Reynolds, Casanova-Romero, Knudson, Kale and Gutierrez realize that there are times when you, the patient, may want another person to be knowledgeable about your medical condition or medical needs. Your doctor wants you to be able, if you so desire, to name a person to whom you want the office staff to speak with about your medical condition. To enable that, we would ask that you complete the form listed below. Please note the following points:

- Only one person can be designated for this role
- The designation is valid until you cancel it in writing
- If you designate no one, PBDES may not be able to release information to any family member or friend.

Designation Statement:

I, ______________________________, designate the following person to be able to speak to a physician at PBDES, a nurse or other staff member, should it be necessary, on my behalf. I hereby give permission to PBDES through its physicians and staff to release to my designee any information about my medical condition or medical needs or the status of my account and I release PBDES, its physicians and staff, from any claim of confidentiality in connections with the release of this information.

Name of Designated Person: ______________________________

Relationship: ________________ Phone Number ____________ (home/work)

Patient's Signature: ______________________________

Date: ____________ Witness: ______________________________

I decline to designate any person to speak with my physician or clinical staff.

Patient's Signature: ______________________________

Date: ____________ Witness: ______________________________