Palm Beach Diabetes & Endocrine Specialists, P.A.

Authorization to Disclose Health Information

Patient Name: _____ Date of Birth: _____

Date of Visit: _____

1. I authorize the use or disclosure of the above-named individual's health information as described below.

2. Medical Records Department of Palm Beach Diabetes & Endocrine Specialists is authorized to make the following disclosure:
   - Entire Medical Record

3. I understand that the information in my health record authorized for disclosure may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse (further redisclosure governed by 42 CFR Part 2).

4. This information may be disclosed to and used by:

   Metabolic Research Institute - 1515 North Flagler Drive, Suite 440 - Phone (561) 802-3060

   to help ensure that the healthcare professionals who will be involved in your care during the course of the clinical trial can make informed decisions about possible treatment options.

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual/organization noted in #2 above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the end of the research study.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. However, if I refuse to sign this authorization, I understand I may be denied treatment that is part of the research study/clinical trial. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for subsequent unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the appropriate Medical Records Department:

   Palm Beach Diabetes & Endocrine Specialists, P.A.(561) 659-3663

_____ _____

Signature of Patient or Legal Representative Date

By signing below, I **decline** to participate in the above.

_____ _____

Signature of Patient or Legal Representative Date

Date: _____ Witness: _____