



DIABETES CARE CENTER

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Diplomates of The American Board of Internal Medicine
Diplomates of The American Board of Endocrinology, Diabetes and Metabolism

PATIENT PRIVACY QUESTIONNAIRE

I authorize Discussion and Release of My General Medical Condition and Diagnosis (including and not limited to treatment, payment and health care operations) to:

1. Name: _____ Relationship: _____

Address: _____

Telephone: _____ DOB: _____

2. Name: _____ Relationship: _____

Address: _____

Telephone: _____ DOB: _____

3. Name: _____ Relationship: _____

Address: _____

Telephone: _____ DOB: _____

Patient Name: _____

(Print)

Patient Signature: _____

Date: _____