DiabeVita
MEDICAL CENTER

FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third-party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past, and to know which drugs are covered by your insurance plan.

By signing below I give permission for DiabeVita Medical Center to access my pharmacy benefits data electronically through RxHub. This consent will enable DiabeVita Medical Center to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub.

_____ _____

Patient Name (PRINTED) Date of Birth

_____ _____

Patient/Guardian Signature Date

PATIENT AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION TO DIABEVITA

PATIENT FOR WHOM HEALTH INFORMATION IS TO BE RELEASED

Last Name _____ First Name _____ Middle _____

Date of Birth: _____ Gender: Male Female

PARTY YOU ARE REQUESTING TO RELEASE HEALTH INFORMATION TO DIABEVITA

Name: _____ Phone _____ Fax _____

Address: _____ City: _____ State: _____ Zip: _____

The party above should send the specified records to us at the address, fax or email below. If there are charges, please advise the patient. Feel free to call us anytime if additional information is needed. We appreciate your cooperation!

DiabeVita MEDICAL CENTER

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SPECIFIC HEALTH INFORMATION TO BE RELEASED

My complete record _____ Laboratory reports only _____ Immunization Records only _____

Only records from service dates from _____ to _____ Other _____

AUTHORIZATION AND RELEASE

By signing below, I hereby consent and authorize the above-named party to release my medical records, including current and past records as specified, to the Diabevita Medical Center. I understand that this authorization includes consent for the release of information, unless limited above, relating to the patient's medical treatment, including psychological or psychiatric conditions, drug abuse, alcoholism, HIV related information (AIDS related testing), cancer testing and results or information protected by State and Federal Laws as related to a minor. I agree that a copy of this release shall be valid as this original.

I understand that I have the right to revoke this authorization at any time, by submitting a revocation of this authorization in writing to the releasing party. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in 90 days.

Signature of Patient or Legal Representative _____

Relationship to Patient _____ Date _____

DiabeVita

AUTHORIZATION FOR DIABEVITA TO RELEASE PERSONAL HEALTH INFORMATION TO OTHERS

Use this form to request DiabeVita Medical Center to release certain medical information about you to a third party. There is no cost if the third party is another health professional we have referred you to or suggested you see as part of your ongoing care. Otherwise there may be a nominal charge which must accompany this request to offset some of our costs of compiling, printing, and sending the records to the third party.

OUR PATIENT FOR WHOM HEALTH INFORMATION IS TO BE RELEASED

Last Name _____ First Name _____ Middle _____

Date of Birth: _____ Gender: Male Female

PARTY TO WHOM PATIENT HEALTH INFORMATION IS TO BE SENT

Recipient Name: _____ Phone _____ Fax _____

Address: _____ City: _____ State: _____ Zip: _____

SPECIFIC HEALTH INFORMATION TO BE RELEASED

My complete record _____ Laboratory reports only _____ Immunization Records only _____

Only records from service dates from _____ to _____ Other _____

AUTHORIZATION AND RELEASE

By signing below, I hereby consent and authorize the release of the above-listed patient's medical records, including current and past records. I am either the patient or legal guardian, and if the latter, I have provided DiabeVita with an executed power-of-attorney by the patient. I understand that this authorization includes consent for the release of information, unless limited above, relating to the patient's medical treatment, including psychological or psychiatric conditions, drug abuse, alcoholism, HIV related information (AIDS related testing), cancer testing and results or information protected by State and Federal Laws as related to a minor. I agree that a copy of this release shall be valid as this original.

I understand that I have the right to revoke this authorization at any time, by submitting a revocation of this authorization in writing to DiabeVita. 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 in 90 days. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the third party and the information may not be protected by federal confidentiality rules. i

Signature of Patient or Legal Representative _____

Relationship to Patient _____ Date _____

FOR DIABEVITA USE ONLY

Request approved _____ Date records sent _____ Records sent via _____

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