

**CARY INTERNAL MEDICINE & THE DIABETES  
CENTER, PA  
103 BAINES COURT  
SUITE 200  
CARY, NC 27511  
PHONE 919-467-6125  
FAX 919-467-1728**

**CONSENT TO DISCUSS MEDICAL CONDITION/  
INFORMATION WITH OTHER INDIVIDUALS**

I, \_\_\_\_\_, give Cary Internal Medicine & The Diabetes Center, PA's staff and physicians permission to discuss my medical condition/information with the individuals listed below. I understand that this consent may be revoked at any time by notifying Cary Internal Medicine & The Diabetes Center, PA in writing of my intent.

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Signed: \_\_\_\_\_ Date \_\_\_\_\_

CARY INTERNAL MEDICINE & THE DIABETES CENTER, PA

I, \_\_\_\_\_, have received a copy of Cary  
Internal Medicine & The Diabetes Center, PA's Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

**Request for limitations and restrictions of Protected Health Information**

How would you prefer that we communicate your protected health information (PHI) with you if you cannot be reached directly? Your PHI includes general health information, laboratory test, diagnostic test results, appointment reminders, and patient demographics/billing information.

**Please answer the following questions by marking YES or NO:**

- 1. Is it ok to leave messages on your home answering machine? YES \_\_\_\_\_ NO \_\_\_\_\_
  - 2. Is it ok to leave messages on your work voice mail? YES \_\_\_\_\_ NO \_\_\_\_\_
  - 3. Is it ok to contact you by your cell phone? YES \_\_\_\_\_ NO \_\_\_\_\_
  - 4. Is it ok to leave a message on your cell phone? YES \_\_\_\_\_ NO \_\_\_\_\_
  - 5. Is it okay to leave a message with your spouse or domestic partner? YES \_\_\_\_\_ NO \_\_\_\_\_
  - 6. Is it okay to leave a message with a family member over 18 years of age? YES \_\_\_\_\_ NO \_\_\_\_\_
- If YES please provide name of person \_\_\_\_\_.

Please list any exception(s) to the above \_\_\_\_\_  
\_\_\_\_\_

Sensitive information such as HIV results, STD results, abnormal results and diagnoses will not be left as messages. Information regarding sexually transmitted diseases will ONLY be released to the patient.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

Or \_\_\_\_\_  
Patients representative

\_\_\_\_\_  
Date