National DPP lifestyle change program referral and authorization release

Send to: **Fax:** **Email:**

Patient information	
First name	Address
Last name	
Health insurance	City
Gender ☐ Male ☐ Female	State
Birth date (mm/dd/yy)	ZIP code
Email	Phone
Health care provider information (completed by provider)	
Physician/NP/PA	Address
Practice contact name	City
Phone	State
Fax	ZIP code

For Medicare requirements, I will maintain this signed original document in the patient's medical record.

Date: _____ **Health care provider signature:** _____

By signing this form, I authorize _____ [name of health care provider] to use and disclose my protected health information described below to _____ [program/organization name] for the purpose of determining my eligibility for the lifestyle change program.

Effective period: This authorization for the release of information will expire on _____ [date].

Extent of authorization: I authorize the release of the following protected health information [check all that apply]

☐ Body Mass Index (BMI)	Eligibility = ≥25 (≥23 if Asian)	_____
Blood test (check one)	Eligible range	Test result (one only)
☐ Hemoglobin A1C	5.7–6.4%	_____
☐ Fasting Plasma Glucose (For Medicare DPP eligible patients, fasting plasma glucose range is 110–125 mg/dL.)	100–125 mg/dL	_____
☐ 2-hour plasma glucose (75 gm OGTT)	140–199 mg/dL	_____

Date of blood test (mm/dd/yy): _____

I understand:

1. That I am not obligated to participate in this lifestyle change program and that this authorization is voluntary.
2. That I may revoke this authorization at any time by notifying my physician in writing. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization, or to the extent that information has already been released in reliance upon this authorization.
3. That my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.
4. That information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Date: _____ **Patient or representative signature:** _____

(Basis of representative's authority to sign on behalf of patient: _____)