

Organization Logo (Header)

Client Consent For Electronic Diabetes Data Sharing

Dear Clients/Substitute Decision Maker:

Sharing of your electronic diabetes data allows us to communicate with you in a timely and efficient way.

What you need to know about communicating with your health care provider when sharing BG data:

- Internet access could be intercepted and read by others over the internet. XXX Organization has systems in place to provide the utmost security however the security of accessing data over the internet cannot be guaranteed.
- When accessing electronic data, all pertinent pieces of information from the reports will be documented in your health record.
- Do not use email to communicate emergency/urgent health matters as email messages can be delayed for various reasons beyond the control of your health care provider. In case of an emergency call 911 or go to your closest Emergency Room.
- **Blood glucose/insulin pump data will only be accessed for the purposes of upcoming appointments or at your request via email (if available at your clinic) or telephone request to discuss a timely concern. It will not be monitored otherwise. In case of an emergency call 911 or go to your closest Emergency Room.**
- You have the right to revoke this permission or remove XXX Organization from accessing your DM data at anytime.

By signing this document, you acknowledge that you have read and agree with the terms outlined in this document. You also agree to inform your healthcare provider at XXX Organization if you no longer wish for your health care team to have access to your diabetes data. This signed document will be stored in your health record. If you have any questions about this process, please speak to anyone on your health care team at XXX Organization.

Consent for Electronic Diabetes Data Sharing:

I (print name) _____ consent to share my electronic diabetes data (blood glucose sensor or insulin pump data) and my user ID/email if required so my care providers at XXX Organization may access my data for assessment and provision of care. This data may be printed and included as part of my health record.

Device/System Name: _____

User Name/Password: _____

E-mail: _____

Clinic ID: _____

Signature: _____ Date(MM/DD/YY): _____

Staff Witness: _____ Staff Signature: _____

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Date: (MM/DD/YY) _____