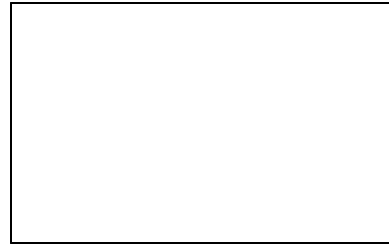


Chicago Southeast Diabetes Community Action Coalition  
Form A.5



**AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION**

I, \_\_\_\_\_, HEREBY AUTHORIZE:  
\_\_\_\_\_  
\_\_\_\_\_ (name or organization) to  
release to :

\_\_\_\_\_  
\_\_\_\_\_

and the Midwest Latino Health Research, Training and Policy Center (Jane Addams College of Social Work-University of Illinois at Chicago) medical information pertinent to my diabetes management requested in the attached document.

- This information will be used to evaluate the impact of the educational, support and case management program on my self-care. I will receive critical information such as hemoglobin A1c, blood pressure, blood glucose levels, lipids, and urine test results in order to improve my self-care.
- This authorization shall be valid for one year after the date of my signature or earlier if revoked by me in writing to the requesting organization.
- I hereby acknowledge that I have been informed of my right to receive a copy of this authorization request.
- I further acknowledge that I have been informed that if medical information herein is not released, my participation in this diabetes program will not be denied.

\_\_\_\_\_  
Participant/Client

\_\_\_\_\_  
Date

Address: \_\_\_\_\_