Judah D Pifer, MD • Brad D Williams, MD

Medical Information {HIPAA) Release Form

This form MUST be completed in its entirety

Name:_____

DOB:_____SSN:_____

Mailing Address: _____ City:_____ St:____Zip:_____

Physical Address:_____City:_____St:____Zip:_____

Should we need to contact you and you are not available; is there someone we could speak with regarding any medical information or financial/insurance information?

Name: _____Phone: _____Relationship:_____

How may we contact you? Is it ok to leave a message?

Primary Phone #_____Main/Home/Cell yes / no

Secondary Phone # _____Main/Home/Cell yes / no

Email:_____

Emergency Contact:_____ Relationship:_____Phone:_____

Secondary Contact: _____ Relationship:_____Phone:_____

Do you have Advance Directives (Living Will}? Yes No

***IF YES - PLEASE BRING WITH YOU TO YOUR APPOINTMEMT*

I acknowledge and am aware of the Notice of Privacy Practices: Yes No

Release of Information I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

- o Spouse:_____
- o Children:_____
- o Other:_____

o Information is not to be released to anyone.

This Release of information will remain in effect until terminated by me in writing.

Signature:_____Date:_____

Patient or legally authorized individual

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ONE TIME AUTHORIZATION

Name:_____ DOB:_____

Consent for Treatment: I authorize performance of necessary medical and/or surgical treatments. These medical services are to be performed by a licensed medical professional and/or appropriate staff of their choice in the medical facility of their choice. (i.e. office, hospital, outpatient facility, etc.}

If patient is a minor, who is authorizing treatment:

Name: _____ DOB: _____SSN: _____

Relationship:_____ Driver's License:_____ Phone: _____

I hereby authorize the above listed providers to furnish information to Insurance Carriers/Workers Compensation concerning my illness and treatments and information needed to determine benefits or benefits for related services. I hereby authorize payment of insurance benefits directly to the above listed billing provider. I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage. I further agree to pay all collection fees, attorney fees and other collection costs that may be incurred to enforce collection of any amount outstanding.

I request that payment of authorized Medicare Benefits be made directly to the above listed billing provider for any services furnished to me by that provider. I authorize the holder of medical information about me to release to the Health Care inancing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize the release of medical records to and from all hospitals, medical service companies, insurance companies and other physicians assisting in the care of the patient. Authorization is also given for a copy of office notes to be mailed to the patient if requested.

Signature: _____ Date:_____

Patient or legally authorized individual

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Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice is effective April 1, 2003.

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your health information
- Your privacy rights

Use and Disclosure of Your Health Information

The office is permitted by federal privacy laws to use and disclose your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include medical history, tests results, diagnosis, treatment, and billing information.

Example of using your health information for treatment purposes:

During the course of your treatment, the physician determines he will need to consult with another physician regarding your treatment. He will share your medical information with that physician.

Example of using your healthcare information for payment purposes:
After submitting a bill to your insurance company, they request medical information from us. We will provide such medical information to them in order to secure payment on your account.

Example of using your healthcare information for health care operations:
We obtain services from business associates such as medical transcriptionists. We will share health information with them, as necessary, in order to obtain services. We do require that they protect the confidentiality of your health information.

In addition to the above, the following circumstances may require us to use or disclose your health information:

- To public authorities and health oversight agencies that are authorized by law to collect information.
- Lawsuits and similar proceedings in response to a court or administrative order.
- If required to do so by a law enforcement official.
- When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or to the public. We will only make disclosures to a person or organization able to help prevent the threat.

- If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- To federal officials for intelligence and national security activities authorized by federal law.
- To correctional institutions or law enforcement officials if you are an inmate or under custody of a law enforcement official.
- For Workers Compensation and similar programs.

Your Rights Regarding Your Health Information

- You can request that our practice communicate with you about your health and related issues in a particular manner or a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
- You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members or friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
- You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the office manager.
- You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the office manager. You must provide us with a reason that supports your request for an amendment. We will review the request and respond to it within 30 days.
- The right to obtain an accounting of certain disclosures of your protected health information made by this office. Please note, the office does not have to track disclosures of protected health information made: (1) prior to April 14, 2003, (2) to carry out treatment, payment or healthcare operations, (3) to persons involved in the patient's care, (4) to the patient or their legally authorized representative, (5) pursuant to a valid authorization or other specific instances as outlined in HIPAA. To obtain an account, submit a written request to the office manager. We will review the request and respond to it within 60 days.
- The right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, please check with any employee at the front desk.
- The right to file a complaint. If you believe your privacy rights have been violated you may file a complaint with our practice or with the Secretary or Department of Health and Human Services. To file a complaint with our practice, contact the office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
- The right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the office manager.

April 2017