PATIENT LAST NAME: _____
PATIENT FIRST NAME: _____
DOB: _____ S.S.NUMBER: _____
PHONE NUMBER: _____

EMERGENCY CONTACT INFORMATION:

NAME:_____ PHONE#_____ CAN WE LEAVE MESSAGE: Y☐N☐
RELATIONSHIP TO PATIENT: _____ POWER OF ATTORNEY: Y☐N☐

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION/ MEDICAL RELEASE:

NAME /ORGANIZATION/ PHYSICIAN:_____ PHONE#_____ FAX#_____
☐ ONLY RELEASE HEALTH INFORMATION ☐ ONLY RELEASE BILLING INFORMATION
☐ RELEASE ALL INFORMATION TO THE ABOVE MENTIONED ☐ ONLY RELEASE:_____

NAME /ORGANIZATION/ PHYSICIAN:_____ PHONE#_____ FAX#_____
☐ ONLY RELEASE HEALTH INFORMATION ☐ ONLY RELEASE BILLING INFORMATION
☐ RELEASE ALL INFORMATION TO THE ABOVE MENTIONED ☐ ONLY RELEASE:_____

HIPAA NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW YOU CAN OBTAIN ACCESS TO YOUR PROTECTED HEALTH INFORMATION (PHI) AT TRI-MED, AND HOW IT MAY BE DISCLOSED AND/OR USED TO CARRY OUT TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS AND OTHER PURPOSES THAT ARE REQUIRED OR PERMITTED BY LAW. PLEASE REVIEW IT AND ACKNOWLEDGE RECEIPT BY SIGNING AND DATING THIS DOCUMENT.

"Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a physician, pharmacy, laboratory, our EMR or billing services provider, Virtual Assistant, durable medical device provider, etc., that will provide, or provides care and services to you. This ensures that the third party has the necessary information to diagnose, treat you, or provide a service needed as part of your care, diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, your protected health information may be disclosed to your health insurance provider to obtain payment or approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in our operations. For example, we could use your information to identify whether you could benefit from new treatment options. We may use your information to contact you or call you by your name while you are in the office.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.
You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and receive copies of your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Our organization is not required to agree to a restriction that you may request, if our organization believes it is in your best interest to permit use and disclosure of your protected health information. In such a case, you have the right to use another Healthcare Professional and receive copies of your medical records or have your medical records sent to your chosen provider.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g. electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Concerns: If you have any questions or concerns regarding your HIPAA related rights at Tri-MED, please ask to speak with 'Nike Aina in person or by phone at (214) 494 2131. Our goal is to meet your needs and fulfill our legal obligations to you. If you are not satisfied and believe your privacy rights have been violated, you may complain to the OCR at the US Department of Health and Human Services, We will not retaliate against you for filing a complaint.

MY SIGNATURE BELOW CONFIRMS THAT I HAVE AUTHORIZED THE RELEASE OF MY PROTECTED HEALTH INFORMATION AS STATED ABOVE. MY SIGNATURE BELOW ALSO CONFIRMS THAT I HAVE RECIEVED, READ, AND UNDERSTAND MY RIGHTS UNDER HIPPA.

Patient Name (Please Print):_____

Signature of Patient or Guardian_____ Witness Signature:_____

Date:_____