PATIENT REGISTRATION

Preferred Pharmacy:___________________ Cross Streets: __________________________ Phone: __________________

Patient Demographics

Last Name: _____________________________ First Name: _____________________________ Middle Initial: _________

Preferred Name:_________________________ ☐Ms. ☐ Mrs. ☐Other_______________________________________

DOB: ____/____/____ SS#: ___________________

Race: ☐American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Pacific Islander ☐ White ☐Other

Ethnicity: ☐ Hispanic/ Latino ☐ Not Hispanic/Latino ☐ Decline Primary

language:__________________________________

Marital Status: ☐ Single☐ Married ☐ Divorced ☐ Domestic Partner ☐ Widowed

Home Address: ____

Home Phone: ___________________ Work: __________________ Mobile: ___________________

Primary: ☐Home ☐ Work ☐Mobile May we leave a detailed message? ☐Yes ☐ No

Email: ____

Preferred Communication: ☐Phone ☐ Mail ☐ Email ☐Text

Employer: ____ Title: ____

Address: ____ Phone Number:___________________________________

Emergency Contact

Last Name: ____ First Name:______________________________________

Address: ____ Phone Number: __________________________________

Insurance Information

Primary Insurance: ____ Effective Date: ____/____/____

Subscriber: ____Member ID: ________________________________

Relationship to subscriber: __________________________________ Subscriber's DOB: ____/____/____

Subscriber's SS#: _____________________________________ Employer:_______________________________________

Secondary Insurance: ____ Effective Date: ____/____/____

Subscriber: ____Member ID: ________________________________

Relationship to subscriber: __________________________________ Subscriber's DOB: ____/____/____

Subscriber's SS#: ___________________________________ Employer: ______________________________________

PLEASE READ THE FOLLOWING CAREFULLY:

- You are responsible for knowing if your insurance is contracted with MyOBGYN.
- You are responsible for knowing your coverage and benefits.
- All deductibles, co-payments and applicable charges will be due at the time of service – **NO EXCEPTIONS**.
- All surgery fees MUST be paid in advance of the surgical date – **NO EXCEPTIONS**.
- For any FMLA/Disability forms there will be a one-time processing fee in the amount of $50.00. It is your responsibility to present these forms to our office via our front desk staff. You will receive a call once the forms are ready for pick-up. Please allow at least 7-10 business days for completion of the paperwork, from date paperwork is received in the office.
- Should you need to cancel or reschedule an appointment, please call at least 24 hours in advance. Failure to do so could result in a $25.00 fee. After three (3) missed appointments, the practice may at its discretion choose to discontinue your care.
- Ultrasound appointments that are cancelled, rescheduled and/or no-showed without a proper 24 hrs notice will result in a $25 no-show fee. After 2 missed appointments the practice will no longer offer in-house ultrasound appointments, a referral for imaging services will be provided.
- LATE TO APPOINTMENT POLICY If you are an established patient and you arrive 15 minutes late or more to your appointment you will likely be asked to reschedule unless the physician's schedule can still accommodate you. Priority will be given to the patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait. If this is not convenient for you, you may choose to reschedule. One or two late patients cause the entire daily schedule to fall behind. This is an inconvenience to everyone. We strive to see every patient as close to their appointment time as possible.
- As a patient at MyOBGYN, I understand that I will be seen by all 3 Providers including Heather K. Bacala MD, Philip G. McLemore Jr. MD, Mary Engelhardt APRN/CNM.

NOTE: If your insurance requires you to utilize a particular laboratory, you will need to inform the nursing staff every time you are seen. If you are not sure whether your insurance company requires you to use a specific laboratory, please contact them directly for that information. There will be a separate bill from the lab for PAP SMEAR interpretation, cultures, urinalysis and other laboratory services.

Notice of Assignment of Benefits and Release of Medical Information

The above information is complete and correct. I hereby guarantee payment of all charges incurred with this office. I hereby assign and direct my insurance company or companies to pay any and all benefits for my medical services directly to this office. I authorize the release of medical information requested by my insurance company or companies to insure payment on this account. I understand that should my insurance company or companies deny any submitted charges for any reason, I am responsible for payment of those charges. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover money due to MyOBGYN.

_________________________________ _________________________________ _____/_____/_____

Patient/ Legal Guardian   Patient Legal Guardian Signature   Date

Name:____________________________________ Age: ________________________ DOB: _____/_____/_____

Primary Care Provider: ____

Personal/ Medical History

Anxiety/Depression ☐ Yes ☐ No

Anemia ☐ Yes ☐ No

Asthma/Lung Condition ☐ Yes ☐ No

Arthritis ☐ Yes ☐ No

Bleeding Disorders ☐ Yes ☐ No

Bowel Disorders ☐ Yes ☐ No

Cancer: ______________________________

Diabetes ☐ Yes ☐ No

Elevated Cholesterol ☐ Yes ☐ No

Endometriosis/ PCOS ☐ Yes ☐ No

Heart Disease ☐ Yes ☐ No

High Blood Pressure ☐ Yes ☐ No

Headaches ☐ Yes ☐ No

Kidney Disease/ Stones ☐ Yes ☐ No

Liver Disease/ Hepatitis ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

Thyroid Disorders ☐ Yes ☐ No

Other: _______________________________

Social History

☐Married ☐ Single☐ Divorced

☐ Widowed ☐ Separated

Do you smoke? ☐ Yes ☐ No

Packs per day: _______________________

Do you drink? ☐ Yes ☐ No

How much? _________________________

Street drugs: ________________________

Marijuana ☐ Yes ☐ No

Sexual Preference: ___________________

Allergies (include medications)

____

____

Gynecological History

Last pap Smear: _________________ ☐Normal ☐ Abnormal

Last Mammo:____________________ ☐Normal ☐ Abnormal

Last Colonoscopy: ________________ ☐Normal ☐ Abnormal

Last DEXA Scan: _________________ ☐Normal ☐ Abnormal

Previous treatment for abnormal pap smear?

☐Colpo ☐Cryo ☐LEEP ☐Conization ☐N/A

Last Menstrual Period: _________________________________

Age of First Period: ____________________________________

Periods Occur Every _________ Days and Last_________ days

☐Heavy ☐ Clots ☐ Pain ☐ Cramping ☐ Irregular bleeding

Average # of pads/ tampons used per day: _______________

Menopausal: ☐Yes ☐ No Age began?: __________________

Hysterectomy: ☐Yes ☐ No When?: ______________________

History of: ☐Breast pain ☐ Infertility ☐ Fibroids

☐ Pain w/ intercourse ☐ Vaginal infections ☐Leaking urine

Decrease in sex drive? ☐ Yes ☐ No

Have you ever been diagnosed with any of the following:

Gonorrhea ☐ Yes ☐ No

Chlamydia ☐ Yes ☐ No

Herpes (Genital) ☐ Yes ☐ No

HPV/ Genital warts ☐ Yes ☐ No

Hepatitis B or C ☐ Yes ☐ No

HIV ☐ Yes ☐ No

Syphilis ☐ Yes ☐ No

Birth Control Method: _________________________________

Previous birth control methods:_________________________

____

____

Pregnancy History

Total number of pregnancies: _________ Miscarriages:_________ Abortions: _________ Ectopic:_________

Live Births: ____________

Date	Gestational Age	Birth Weight	Gender	Vaginal or C-Section	Complications

Surgical History

Ablation Date: _______________ Laparoscopy Date: ________________

Breast surgery Date: _______________ Ovaries removed Date: ________________

D&C Date: _______________ Tubal ligation Date: ________________

Hysterectomy Date: _______________

□ Appendectomy □ Back Surgery □ Bowel □ Fibroid removal □ Gallbladder □ Tonsillectomy

Other: ____

Family History

Breast Cancer □ Yes □ No Family Member: ____

Ovarian Cancer □ Yes □ No Family Member:____

Colon Cancer □Yes □ No Family Member: ____

Other: ____

____

Current Medication (list all medications taken daily)

___________________________ Dose: ____________________________ Frequency: _____________________

___________________________ Dose: ____________________________ Frequency: _____________________

___________________________ Dose: ____________________________ Frequency: _____________________

___________________________ Dose: ____________________________ Frequency: _____________________

Electronic Prescription (ePriscribing) Consent Form

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBMs are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an ePrescribe program. These include:

- Formulary and benefit transactions-- Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions--Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events.

By signing this consent form you are agreeing that MyOBGYN can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Patient Name (printed): ____ DOB: _____/_____/_____

Signature of Patient: ____ Date: _____/_____/_____

Relationship (if other than patient): ____

Consent Denied: ____ Date:_____/_____/_____

Notice of Privacy Practices NPP

This Notice describes how medical Information about you may be used and disclosed and how you can get access to this information. Please Review Carefully.

Who Will Follow This Notice

We may use your medical information for treatment, payment, Practice or Facility operations, research or fundraising purposes as described in this notice. All employees of My OBGYN follow these privacy practices. The physicians on our medical staff will also follow this notice when they work at the Practice or Facility.

About This Notice

This notice will tell you about the ways we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

- make sure that medical information that identifies you is keptprivate;
- give you this notice of our legal duties and privacy practices with respect to your medical information;
- follow the terms of the notice that is currently in effect; and
- notify individuals, either known or reasonably believed to be affected, following a breach of unsecured protected health information.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and give examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one or more of the categories.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other Practice or Facility personnel who are involved in your care. Different departments of the Practice or Facility also may share medical information about you in order to coordinate the different services you may need, such as prescriptions, lab work and imaging services. We also may disclose medical information about you to people outside the Practice or Facility who may be involved in your medical care.

For Payment: We may use and disclose medical information about you so that we may bill for treatment and services you receive at the Practice or Facility and collect payment from you, an insurance company or another party. For example, we may need to give information about the medical care you received at the Practice or Facility to your health plan so that the plan will pay us or reimburse you for the applicable treatment. We may also tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment. We may also disclose information about you to other healthcare facilities for purposes of payment as permitted by law.

Appointment Reminders: We may use and disclose medical information to contact you to remind you that you have an appointment for treatment or medical care.

Treatment Alternatives: We may use and disclose medical information to tell you about possible treatment options that may be of interest to you.

For Healthcare Operations: We may use and disclose medical information about you for operations of the Practice or Facility. These uses and disclosures are necessary to run the Practice or Facility and make sure that all of our patients receive quality care. For example, we may use medical information to evaluate the performance of our staff in caring for you. We may als combine medical information about many patients to decide what additional services the Practice or Facility should offer, what services are not needed and whether certain new treatments are effective. We may also combine medical information we have with medical information from other Practices or Facilities to compare our performance and to make improvements in the care and services we offer. We may also disclose information to doctors, nurses, technicians,

medical students and other Practice or Facility personnel for educational purposes. We may also disclose information about you to other healthcare facilities as permitted by law.

Health-Related Benefits and Services: We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information to balance research needs with patients' needs for privacy of their medical information. Before we use or disclose medical information for research, the project will be approved through this process. However, we may disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Practice or Facility. When required by law, we will ask for your specific written authorization if the researcher will have access to your name, address or other information that reveals who you are or will be involved in your care at the Practice or Facility.

As Required By Law: We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Special Situations
Nevada State Law. Special privacy protections apply to genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you will be provided an explanation of how the information will be protected. For further information, please contact the Privacy Officer. This contact information is listed on the last page of this Notice.

Organ and Tissue Donation: If you are an organ or tissue donor, we may release medical information about you to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank.

Military and Veterans: If you are a member of the armed forces of the United States or another country, we may release medical information about you as required by military command authorities.

Workers' Compensation: We may release medical information about you for workers' compensation or similar programs.

Public Health Risks: We may disclose to authorized public health or government officials medical information about you for public health activities. These activities generally include the following:

- to a person subject to the jurisdiction of the Food and Drug Administration (FDA) for purposes related to the quality, safety or effectiveness of an FDA- regulated product or service;
- to prevent or control disease, injury or disability;
- to report disease or injury;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications and food or problems with products;
- to notify people of recalls or replacements of products they may be using;

- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized bylaw.

Health Oversight Activities: We may disclose medical information about you to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request or other legal demand by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release medical information about you if asked to do so by a law enforcement official:
- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness or missing person;
- about the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at the Practice or Facility or by healthcare providers affiliated with the Practice or Facility;
- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime; and
- to authorized federal officials so they may provide protection for the President and other authorized persons or conduct special investigations.

Coroners, Medical Examiners and Funeral Directors: We may release medical information about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information to funeral directors so they can carry out their duties.
National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.
To a School: We may disclose information to a school, about an individual who is a student or prospective student of the school, if:
- The protected health information that is disclosed is limited to proof of immunization;
- The school is required by State or other law to have such proof of immunization prior to admitting the individual;and
- The covered entity obtains and documents the agreement to the disclosure from either:
  - A parent, guardian, or other person acting in loco parentis of the individual, if the individual is an unemancipated minor; or
  - The individual, if the individual is an adult or emancipated minor.

Your Rights Regarding Medical Information About You
You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records. This right does not include psychotherapy notes, information compiled for use in a legal proceeding or certain information maintained by laboratories. In order to inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer listed on the last page of this Notice for the location at which you were treated. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request in writing that the denial be reviewed. To request a review, contact the Privacy Office. This contact information is listed on the last page of this Notice. A licensed healthcare professional will conduct the review. We will comply with the outcome of the review.

Right to Amend: If you think that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Practice or Facility. To request an amendment, your request must be made in writing and submitted to the Privacy Officer, listed on the last page of this Notice, for the location at which you were treated. In addition, you must give a reason that

supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for the Practice or Facility
- is not part of the information that you would be permitted to inspect and copy;or
- is accurate and complete.

We will provide you with a written notice of action we take in response to your request for an amendment.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you. We are not required to account for any disclosures you specifically requested or for disclosures related to treatment, payment or healthcare operations or made pursuant to an authorization signed by you. To request an accounting of disclosures, you must submit your request in writing to the Privacy Office. This contact information is listed on the last page of this Notice. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. We will attempt to honor your request. If you request more than one accounting in any 12-month period, we may charge you for our reasonable retrieval, list preparation and mailing costs for the second and subsequent requests. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. Additionally, you can request restrictions on medical information disclosed to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the information pertains solely to a health care item or service for which you, or person other than the health plan on your behalf, has paid us in full. To request a restriction, you must contact the Privacy Office. This contact information is listed on the last page of this Notice.

We are not required to agree to your request: If we agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment. You may terminate the restriction at any time. If we terminate the restriction, we will notify you of the termination. We are not able to terminate or refuse your request for restrictions to disclosures to health plans if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and the information pertains solely to a health care item or service for which you, or person other than the health plan on your behalf, has paid us in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must submit a written request to the Privacy Office. This contact

information is listed on the last page of this Notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will attempt to accommodate reasonable requests.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice at your first treatment encounter at the Practice or Facility. You may get an additional copy of this Notice at any time by contacting the Privacy Office. This contact information is listed on the last page of this Notice.

Changes to this Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information about you we already have as well as any information we receive in the future. We will post copies of the current Notice at the Practice or Facility. The Notice will contain on the first page, in the bottom right-hand comer, the effective date. In addition, each time you register at the Practice or Facility for treatment or healthcare services, we will provide available copies of the current Notice. Any revisions to our Notice will also be posted on our website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Practice or Facility or with the Secretary of the Department of Health and Human Services, Office of Civil Rights. To file a complaint with the Practice or Facility, please call or write to the Privacy Office. This contact information is listed on the last page of this Notice. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not described in this Notice or the laws that apply to us will be made only with your written authorization on a Practice or Facility authorization form. If you provide us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. However, we may continue to use or disclose that information to the extent we have relied on your authorization. You also understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

Acknowledgement of Receipt of the Notice of Privacy Practices (NPP)

I hereby acknowledge that I have received from My OBGYN a copy of the Notice of Privacy Practices of My OBGYN. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how My OBGYN can use and disclose my personal health information both with and without my authorization. I further understand that I may contact My OBGYN Privacy Officer, Claudia Luna, if I have any questions regarding the contents of this Notice or to file a complaint.

____
Patient Name

____ _______/______/_______
Patient/ Healthcare Agent/ Guardian/ Relative Signature Date

Authorization for Release of Medical Information

Patient Name	Date of Birth	Medical Record Number
Patient Address	City	State/Zip Code

I, or my authorized representative, request that health information regarding my health care and treatment as forth on this form:
In accordance with Nevada State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **Alcohol** and **Drug Abuse, Mental Health Treatmen**t, **Genetic Testing**, and **Confidential HIV Related Information**. only if I place my initials on the appropriate line in item 6(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in item 6(a), I specifically authorize release of such information to the person(s) indicated in item 6(d).
2. If I am authorizing the release of alcohol, drug abuse treatment, mental health treatment, genetic testing, or HIV-related information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without my authorization. If I experience discrimination because of the release of disclosure of HIV-related information or believe my personal health information has been disclosed without my consent, I may contact the Nevada Attorney General at 775-684-1108 or the Regional Office for Civil Rights Region IX at 800-368-1019. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I further understand that if I am authorizing the release of my health information to the care provider listed below to seek payment for health care provided to me, I cannot revoke the authorization to the extent that the records are needed to secure payment for these services.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in item 2), and this re-disclosure may no longer be protected by federal or state law.
6. **This Authorization Does Not Authorize You to Discuss my Health information or Medical Care with Anyone Other Than the Attorney, Governmental Agency, Provider, Person OR Entity Specified IN ITEM 6(B)**

6 (a) Specific information to be released:

- ☐ Medical records (office notes, radiology studies, lab results from: ____/____/____ to ____/____/____
- ☐ Medical records (office notes, radiology studies, lab results for the past year ONLY.
- ☐ Last 4 pap smear ☐ Last 4 mammograms ☐ Last 4 DEXA scan
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consult, billing records, insurance records, and records received from other healthcare providers.
- ☐ Sensitive records request: (indicated by initialing) ______ **Alcohol/Drug treatment** _____ **Mental Health Information** ______ **HIV-Related Information** _____ **Genetic Information**

Authorization to Discuss Health Information

6(b) By initialing here _____ I authorize ___________________________________ to discuss my health information with my attorney, governmental agency, other care provider(s) or person (s) listed below:

____

6(c) Authorizing release of records from (provider/facility): ____

6(d) Release records to: ____
Name of Health Care Provider/ Insurance/ Other

6(e) Address to mail records: ____

7. Reason for release of information: ☐ Transferring Medical Care ☐ Primary Care Provider ☐ Consulting Provider ☐ Personal Records ☐ Insurance Eligibility/Benefits ☐ Moving Out of State ☐ Legal Investigation ☐ Other ______________________________________

8. Expiration date of authorization :_____/_____/_____ Expiration event of authorization :______________________________________
(If no expiration date or even is selected, authorization will expire in one (1) year)

9. If not the patient, name of person signing form: ____

10. Authority to sign on behalf of patient: ____

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form. I further understand that there may be a copy fee of $0.60 per page charge.

____ ________/________/__________
Signature of patient or representative authorized by law **Date**

Acknowledgement of Health Insurance Portability and Accountability Act (HIPPA) and Confidential Communications

I am aware that the Privacy Practices Notice is posted in the main lobby for my review and that I have the right to a copy at my request.

The HIPPA privacy rule allows patients the right to place a restriction on uses and disclosures of their protected health information (PHI). Additionally, patients have the right to request confidential communications or that a communication of PHI be made by alternative means.

I wish to be contacted in the following manner: (Check all that apply)

Methods selected below do not apply to appointment reminders

□ Home Phone
- □ ok to leave message with detailed information
- □ ok leave message with call back number only

□ Work Phone
- □ ok to leave message with detailed information
- □ ok leave message with call back number only

□ Mobile Phone
- □ ok to leave message with detailed information
- □ ok to leave message with call back number
- □ ok to text message with call back number only

□ Written Communication
- □ ok to mail to my home address
- □ ok to email to :_________________________

Patient Portal Communication Notification: by registering for the Patient Portal, the patient has given the practice permission to communicate detailed information through secure messaging. The patient will have to log in to the portal using their personal username and password to read any secure messages that are received. To learn more about the Patient Portal, please speak to the front office staff to register.

I authorize the release of all my protected health information to:

Name ____ DOB _______/_______/_______
Relationship to patient:
□ Spouse □ Parent/Guardian □ Child □ Other: ____________________________________
Home Phone: ________________ Mobile: __________________ Work Phone:______________

Name ____ DOB _______/_______/_______
Relationship to patient:
□ Spouse □ Parent/Guardian □ Child □ Other: ____________________________________
Home Phone: ________________ Mobile: __________________ Work Phone:______________

____ ________/________/________
Patient Name DOB

____ ________/________/________

Patient Signature

Date