HIPAA Privacy Authorization Form.

Authorization for Use or Disclosure of Protected Health Information

I authorize MedNova Primary Care to use and disclose my protected health information as described below:

1. Extent of Information to be released
   a. I authorize the release on my COMPLETE health record (including records related to my mental health a well as treatment of alcohol and/or drug abuse**. Initials:** ___________
   b. I authorize the release of my COMPLETE health record with the EXCEPTION of the following information **(please initial next to the record to exclude)**
      1. ____ Mental Health records
      2. ____ Alcohol/Drugs Abuse treatment
      3. ____ Other: (please specify): ____

2. This medical information may be used by the entity I authorize to receive this information for medical treatment, consultation, billing/claims, payments, or other purpose as I may direct.

3. This authorization shall be force and effective until
   a. _____________________________ **(list date)**
   b. Twelve months form date this form is signed. **Initials:** ________

4. I understand that I have the right to revoke this authorization at any time. I further understand that in order to revoke I must submit in writing. I understand that the revocation is not effective to the extent that the person/entity has already acted in reliance on my authorization was obtained as a condition of obtaining insurance coverage and the insurer has the legal right to contest claim.

5. I understand that my treatment, payment, enrollment, and/or eligibility for benefits will not be conditioned on whether I sign this authorization.

6. I understand the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state laws.

7. I authorize the release of information to include diagnosis, records, exams rendered to me and claims data to the following individuals:
   a. Spouse: Name: ____
   b. Child(ren): Name: ____
   ____
   c. Other (please indicate relationship): ____

8. Messages regarding my healthcare may:
   a. May we phone, email, or send a text to you to confirm appointments? ___ Yes ____ No
   b. May we leave a message on your answering machine at home or on your cell phone? __ Yes ___ No
   c. [ ] NOT to be left on any messaging system.

___________________________ ______________________ ______________________________

Signature Printed Name Date

Patient Consent for Use & Disclosure of Protected Health Information

I hereby give my consent for MedNova Primary Care to use and disclose protected health information about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by MedNova Primary Care describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. MedNova Primary Care reserves the right to revise its Notice of Privacy Practices at any time. A Notice of Privacy Practices may be obtained by forwarding a written request to MedNova Primary Care.

With this consent, MedNova Primary Care may call my place of residence or other alternative location and leave a message on voice-mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, MedNova Primary Care may mail to my home or other alternative location any items that assist the practice in carry out TPO, such as appointment reminder cards and patient statements. I have the right to request that MedNova Primary Care restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by the agreement.

By signing this form, I am consenting to allow MedNova Primary Care to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, MedNova Primary Care may decline to provide treatment to me.

TPO Definition: Treatment, Payment, Operation

Signature: ______________________________________ **Date:** ______________________

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACT PRACTICE

____ ______________________________

Name of Patient **Date of Birth**

MedNova Primary Care

Clinic/Doctor

NOTICE OF PRIVACY PRACTICES

- The Notice of Privacy explains in detail how MedNova Primary Care may use and share my health information for other than treatment, payment, and health care operations.
- MedNova Primary Care will use and share my health information as required/ permitted by law.
- MedNova Primary Care will use my health information for the purpose of my treatment, payment for my treatment and MedNova Primary Care health care operations.
- You should review Med Nova's "Notice of Privacy Practice" prior to signing this Acknowledgment. You have the right to request a restriction of the uses and disclosure of your Protected Health Information (PHI) for the purpose of your treatment, payment for your services, and the healthcare operations of MedNova Primary Care. We are not required to agree to the requested restrictions but we are bound by any restrictions agreed upon.
- MedNova Primary Care reserves the right to change the Notice and will notify all patients of such changes prior to the effective date.

ACKNOWLEDGEMENT

I acknowledge that have been provided the Notice of Privacy Practice for MedNova Primary Care

____ ____________________

Signature of Patient or Patient's Legal Representative **Date**

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Printed name of Patient or Patient's Legal Representative
(Include legal documentation if note on file already)