

HIPAA Information, Release and Authorization

1. I hereby authorize Arlington Surgical Association, P.A. to release to: _____

Patient Name

Birth Date

Chart #

2. Information to be released from _____ to _____.
Date Date

___All of the following: ___Op Notes ___Discharge Summary ___Pathology Report

___Lab Reports ___Radiology Reports ___Office Visit Notes* ___HIV Results

___Other _____

*The physician's Office Notes are not routinely included in Medical Records. Permission from the physician must be obtained before Office Notes will be released.

3. The above information is released for the following purpose and that purpose only

___Medical Care ___Attorney _____
(Purpose)

___Insurance ___Other: _____
(Purpose)

4. I also understand that I may revoke this authorization at any time to the extent that action has been taken in reliance on it (e.g., probation, parole, etc), and that in any event this authorization expires automatically as described above.

5. **This authorization will expire ninety (90) days from the date of my signature or as otherwise specified by date, event or condition as follows:** *This may be revoked in writing at any time.*

6. With respect to any mental health information that may be contained in the patient's medical records, I hereby waive my/his/her right to the privileges of confidentiality.

7. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulation.

8. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

9. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name _____ Phone number _____

Name _____ Phone Number _____

10. Please print the address of where you would like your billing statements and /or correspondence from our office to be sent **if other than your home**.

11. Please indicate if you want all correspondence (except billing statements) from our office sent in a sealed envelope marked "CONFIDENTIAL". YES NO (circle one)

12. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number: _____

13. **I am fully aware that a cell phone is not a secure and private line.** _____ **Initial**

14. Can confidential messages (i.e. lab & x-ray reports) as well as calls to reschedule appointments be left on your telephone answering machine or voice mail? YES NO (circle one)

15. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. _____ **Initial**

This Office has made available and their Notice of Privacy Practices and I have reviewed this Office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient/Guardian Signature

Date

Disclosure of Ownership Interest in USMD Hospital at Arlington

The Physicians of Arlington Surgical Association, P.A. have exercised their independent medical judgment in determining that it is in your best interest to receive certain prescribed medical care at USMD Hospital at Arlington (the "Hospital"). The purpose of this disclosure statement is to inform you that Physicians possess a direct ownership interest in the Hospital. No remuneration received directly or indirectly by the Physicians as a result of this ownership interest in the Hospital requires, nor is it contingent upon the admission, recommendation, referral, or any other form of arrangement for utilization by patients or others of any item or service offered by the Hospital. Decisions regarding the admission, recommendation, referral or any other form of arrangement for utilization by patients of the Physicians or specific services or facilities are made with regard to the best interests of each individual patient.

The Physicians are required by law to disclose to you this financial interest in the Hospital, and to advise you that you have the option of choosing an alternative health care facility should you so desire.

I have read, understand and acknowledge the above Disclosure.

Signature of Patient or Personal Representative

Date