AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND TRANSFER OF CARE

Patient Name:______________________________ **Date of Birth:**______________________________

Phone: H) ______________________________ **Phone: W)** ______________________________

Address: ______________________________ **City/State/Zip:** ______________________________

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: ______________________________ **Facility Phone:** ______________________________

Facility Address:______________________________ **Facility Fax:**______________________________

City, ST, Zip: ______________________________

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: ______________________________
☐ Specific Information Requested:

____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other______________________________

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Fax: ______________________________ **Phone:** ______________________________

☐ **Please mail records.**
☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ______________. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization. I also acknowledge that by signing below I agree to transfer my care to the above listed facility.

X______________________________ ______________________________

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

______________________________ ______________________________

Printed name of Authorized Representative

Relationship / Capacity to patient

____

Address and telephone number of authorized representative

Authorization to Disclose Health Information to other Providers

Patient Name: ____ **Date of Birth:**

I hereby authorize the disclosure of my individually identifiable health information as described below.

(a) Name: ___________________________________

(b) Persons/organizations authorized to make requested disclosure of the information: ____________________

(c) Providers/organizations to whom the disclosure may be made:____________________________________

(d) Specific description of information to be disclosed (including descriptive date(s)):

____ ____________________________

____ ____________________________

(e) Specific purpose of the disclosure: ____

(f) This authorization will expire *(indicate date, or an event relating to you personally or to the purpose of the authorization)*: ____

Protected Health Information ("PHI") may include information/documents regarding medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third-party financing.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") govern the terms of this Authorization.

I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the persons/organizations identified in item (b) below providing the information. This right is described in Company's Notice of Privacy Practices.

I understand that I am not required to sign this Authorization and my execution of this Authorization is not condition for treatment.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA. However, sale of PHI or use of the information for marketing by a third party that renumerates the provider should be explicitly stated.

HIPAA regulations authorize the release of PHI to other providers for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of ____________________________________ Other than those releases authorized by HIPAA, PHI will only be released to persons/organizations listed on this authorization and stated purpose.

This authorization shall be effective for twelve (12) months, which ends on __________________________________.

____ ____

Signature of Patient or Personal Representative Relationship of Personal Representative to Patient

Date of Authorization______________________________

CONSENT FOR TREATMENT

This consent will be effective after the date it is signed at *Seegott Health LLC, dba TruCare.*

Consent for Treatment/Care

As patient/parent/authorized representative, I hereby voluntarily give my consent to the rendering of such care including diagnostic procedure, medical and surgical procedure and treatment as prescribed by a duly licensed physician, healthcare facility or their authorized designees, as may in their professional judgment be necessary to provide for the medical, surgical or emergency care.

I have accurately completed the Medical History intake information form, identified all the medical/physical conditions, medications I/patient is taking (including over-the-counter), and known allergies.

I understand that *Seegott Health LLC, dba TruCare* depends on information I have provided, and any discrepancies may complicate the treatment, cause injury and/or reduce my chances of successful treatment outcome. If there is any change in any of my medical history, I agree to provide all updated information.

I acknowledge that no guarantee has been made to me as to the effect of such examinations or treatment.

Financial Responsibility

I understand and agree that I assume financial responsibility to all charges for medical and related professional services performed or by a physician and/or healthcare facility. I also understand that an insurance company may not pay the full amount of my charges, and I may be responsible (as a patient, spouse, or the parent of a minor child) for the amount not paid. If I do not have health insurance or have not provided current or accurate insurance information, I am responsible for payment of all charges.

I understand my signature constitutes my acknowledgement that:

1. I have read and agreed to the foregoing;
2. The diagnostic procedures and/or treatment have been adequately explained to me by the health professional and that I have received all information I desire concerning the same;
3. That I authorize the consent to the diagnostic procedures and/or treatment; and
4. I am releasing the healthcare facility from liability.

I understand that I may withdraw this consent in writing. My withdrawal will not be effective for actions already taken, or in progress.

I have read this form, received a copy, and I am the patient or authorized to act on behalf of the patient.

PATIENT SIGNATURE: ________________________________
PRINTED NAME: ______________________________________
DATE & TIME: _______________________________________
RELATIONSHIP, if not patient: ____________________________

WITNESS: __________________________ DATE: _________TIME: ___________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice outlines the ways in which Seegott Health LLC, dba TruCare ("Company"), may use and disclose medical information about you, which discloses your individual identity.

Company protects you with respect to disclosure of your Protected Health Information by:

- limiting who may see, use and further disclose this information, and
- informing you of our legal duties and your legal rights respecting this information.

This Notice and the referenced Privacy Policy and Use and Disclosure Procedures are required by a new federal regulation known as the "Privacy Rule," applying to as a "provider" and, in some cases, as an "indirect provider" and/or "business associate".

This Notice also outlines Company's obligations and your rights regarding the use and disclosure of Protected Health Information. Company is required by law to maintain the privacy and security of your Protected Health Information and to notify you promptly following a breach of unsecured Protected Health Information, and to comply with the terms of the Notice that is currently in effect. Your information will not be used or shared other than as described in this Notice unless you provide written approval to do so. If you do provide written approval, you may change your mind at any time by written request.

This Notice summarizes the HIPAA privacy rights and obligations of all parties who have access to your Protected Health Information, including providers of health care services who have direct treatment relationships with you.

Administration of all your rights is placed with the Privacy and Security Officer designated herein, at the end of this Notice ("Privacy and Security Officer").

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ABOUT YOU

For Treatment (as Provider). We may use Protected Health Information about you in your treatment. This may include uses and disclosures to provide, coordinate, manage or supplement your health care and related services.

For Payment (as Provider). We may use and disclose Protected Health Information about you to bill or collect for the treatment and services we provide.

For Healthcare Operations (As Provider). We may use and disclose Protected Health Information about you in performing business activities called "healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation certification, licensing or credentialing activities.

As Required by Law. We will disclose relevant Protected Health 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 Protected Health 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.

Law Enforcement. We may release Protected Health Information about you if asked to do so by a law enforcement official such as: in response to a court order, subpoena, warrant, summons or similar process.

Health Oversight Activities. We may disclose Protected Health Information about you to a health oversight agency for oversight activities authorized by law.

National Security and Intelligence Activities. We may release Protected Health Information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

To your family and friends. We must disclose your health information to a family member, friend or other person to the extend necessary to help with your healthcare or payment for your healthcare, but only if you agree that we may do so.

YOUR RIGHTS WITH RESPECT TO PROTECTED HEALTH INFORMATION

You have the following rights regarding Protected Health Information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and obtain a copy of Protected Health Information about you, with limited exceptions. You may request that we provide copies in a format other than photocopies unless we cannot practically do so. 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.

Right to Amend. You have the right to request an amendment of Protected Health Information about you for as long as the information is kept by or for the Company. To request an amendment, your request must be made in writing and submitted to the Privacy and Security Officer. In the written request, you must provide a reason that supports your request.

Right to an Accounting of Disclosures. You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities. You can ask for a list of the times we have shared your Protected Health Information for six (6) years prior to the date you ask, who we shared it with, and why.

Right to Request Restrictions. You have the right to request that we place additional restrictions or limitation on our use or disclosure of your Protected Health Information. We are not required to agree with these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Right to Request Confidential Communications. You have the right to request that we communicate with you about Protected Health Information about you by alternative means or at alternative locations. To request confidential communications, you must make your request in writing to the Privacy and Security Officer. Your request must specify how or where you wish to be contacted.

Right to Copies of This Notice. You have the right to paper and electronic copies of this Notice. You may ask us to give you a copy of this Notice at any time.

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 we already have about you as well as any information we receive in the future. All material changes or revisions to the Notice will be prominently posted on the website by the effective date of such changes. The new notice will be available upon request, in our office, and on our web site.

COMPLAINTS

If you believe your privacy rights as described in this Notice have been violated, you may file a complaint with Company or with the Secretary of the U. S. Department of Health and Human Services. To file a complaint with Company, contact the Privacy and Security Officer who will provide you with a copy of the complaint procedure upon request. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

QUESTIONS

If you have any questions about this Notice, please contact the Privacy and Security Officer.

The following individual is designated by Company for purposes of HIPAA Privacy compliance:

Privacy and Security Officer: Jennifer Seegott, (772) 255-6565, jennifer@trucaretc.com

Acknowledgment of Receipt

I acknowledge that I received a copy of the Privacy Practices Notice.

____
Print name

____
Signature

____
Date