



### Release of Confidential Information

I, \_\_\_\_\_ hereby give my consent to ENT & Allergy

*(Name of patient or authorized agent)*

Specialists of Shady Grove to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of \_\_\_\_\_.

I acknowledge the review and/or receipt of the physician's Notice of Privacy Practices (see next page). The Notice provides detailed information about how the practice may use and disclose my confidential information. I understand that ENT & Allergy Specialists of Shady Grove has reserved the right to change its privacy practices, and that a copy of any revised Notice will be available to me upon written request.

I also authorize the physicians and staff of ENT & Allergy Specialists of Shady Grove to (please reply to all three):

1. Leave a message requesting a return call at the following daytime number:

(\_\_\_\_\_) \_\_\_\_\_ (this is my  cell  home number  work number)

2. Leave a detailed message with the type of test(s) performed, test results and/or any other comments related to my health at:

(\_\_\_\_\_) \_\_\_\_\_ (this is my  cell  home number  work number)

3. Release any and all information pertaining to my health care, test results, procedures, billing and/or accounting information to the following person(s) or agencies:

\_\_\_ Spouse \_\_\_ Parents \_\_\_ None \_\_\_ Other (please specify): \_\_\_\_\_

Name and phone number: \_\_\_\_\_

I understand that this consent will be actively enforced and that if I wish to change the status of this form, I must do so in person and in writing.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

If not the patient, please specify relationship to the patient: \_\_\_\_\_

Patient refused to sign ( ) Witnessed by: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

The Department of Health and Human Services, Office of Civil Rights, under the Public Law 101-191, (The Health Insurance Portability and Accountability Act of 1996) (HIPAA), mandates that we issue this new revised Privacy Notice to our patients. This notice to our patients meets all current requirements as it relates to Standards for Privacy of Individually Identifiable Health Information (IIHI) affecting our patients. You are urged to read this notice.

As part of the Privacy Standard, implemented on April 14, 2003, every patient must receive our new Privacy Notice and execute a new Consent Agreement.

Our Privacy Notice informs you of our use and disclosure of your Protected Health Information (PHI), defined as: any information, whether oral or recorded in any medium, that is either created or received by a health provider, health plan, public health authority, employer, life insurance company, school or university or clearinghouse and that relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual.

Our office will use or disclose your PHI for purposes for treatment, payment and other health care purposes as required, to provide you the best quality health care services that we offer to the extent permitted by your Consent Agreement or in such specific situations, by your signed and dated Authorization. It is our policy to control access to your PHI; and even in cases where access is permitted we exercise a "minimum necessary information" restriction to that access. We define the minimum necessary information as the minimum necessary to accomplish the intent of the request.

An Authorization differs from a Consent Agreement in that it is very specific with regard to the information allowed to be disclosed or used, the individual or entity to which the information may be disclosed to, the intent for which it may be disclosed, and the date that it was initiated which may include the duration for the authorization. This is a form, separate from the Consent Agreement, and usually used only for one specific request for information. In the event of a non-health care related request for personal health information this office will request you to complete an Authorization Form.

You, as our patient, may revoke any consent Agreement or Authorization at any time, and all use and disclosure and administration of related health care services will be revised accordingly, with the exception of matters already in process as a result of prior use of the PHI. To revoke either the Consent Agreement or the Authorization you will have to provide this office with a written request with your signature and date and your specific instructions regarding an existing Authorization or Consent Agreement. Any revocation will not apply to information already used or disclosed. If you had a "personal representative" initiate an Authorization, you may revoke that authorization at any time.

You, the patient, have access to your health care information and may request to examine your information, may request copies of your information, and under the law you may request amendments to your information, The physician or principal will exercise

professional judgment with regard to requests for amendments and is not bound by law to make any changes to the information. If the physician or professional agrees with the request to amend the information, we are bound by law to abide by the changes.

In limited circumstances, The Privacy Standard permits, but does not require covered entities to continue certain existing disclosures of health information without individual authorization for specific public responsibilities.

These permitted disclosures include: emergency circumstances; identification of the body of a deceased person, or to assist in determining the cause of death; public health needs; research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. There are specific state laws that require the disclosure of health care information related to Hepatitis C and AIDS. Where the state laws are more stringent than HIPAA Privacy Standard, the state laws will prevail.

All of these disclosures could occur previously under former laws and regulations, however, The Privacy Standard establishes new safeguards and limits. If there is no other law requiring that your information be disclosed, we will use our professional judgment to decide whether to disclose any information, reflecting our own policies and ethical principles.

On some occasions we may furnish your PHI to a third party. This could be an insurance company for the purpose of payment or another health care provider for further treatment or additional services. Although we will institute a "chain of trust" contract and monitor our business associates' contracts with us, we cannot absolutely guarantee that they will not use or disclose your PHI in such a way as to violate the Privacy Standard.

Although the law requires a signed and dated Privacy Notice, this office does not demand that you sign this agreement as a condition of receiving care. It is the law that your rights are communicated in this manner.

In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff in the law, and implanted policies to protect your PHI. We have instituted privacy and security processes to guard and protect your IIHI. This office is taking and continues to monitor and improve steps for the protection of your information and to remain in compliance with the law.