HIPAA Notice of Privacy Practices
Central Medical Clinic

Patient Name: ______________________________
DOB: ________________ DOS: ________________

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Notice of Privacy Practices Describes how we may use and disclose your protected health information (PHI) to carry out treatment. Payment of healthcare operations (TPO) and for the purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. ***I authorize Central Medical Clinic to release my Protected Health Information in accordance with its Notice of Privacy Practices. Patient Initial(s)________***

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care an any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you or a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. ***I give consent to Central Medical Clinic, any associates, assistants and other healthcare providers deemed necessary, to treat your condition. I understand that no warrant or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize effectiveness. Patient Initial(s)________***

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a procedure may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities. For example, we call you by name in the waiting room when your physician is ready to see you. We may disclose your protected health information, as necessary, to contact you to remind you of your appointment. ***I give consent to Central Medical Clinic to release information for billing purposes. Patient Initial(s) ________***

Medication History Consent:

A medication history is a list of medications that Central Medical Clinic and other doctors have recently prescribed for a patient. It is collected from a variety of sources, including a patient's pharmacy, health plans, other healthcare providers, and the Minnesota State Pharmacy Board. ***I give consent for Central Medical Clinic to retrieve and review your medication history. It is understood that this information will be part my medical record. Patient Initial(s)__________***

I authorize Central Medical Clinic to Proceed as indicated in the above sections. I hereby acknowledge I have been provided with or have been offered Central Medical Clinics Notice of Privacy Practices (HIPAA).

Signature: ____ Date: _________________________

Consent to Share Personal Information with Another Individual

I hereby authorize Central Medical Clinic to discuss information regarding my treatment with:

Name: ____ Relationship: ____