# East Florida Premium Medical Care

# NOTICE OF PRIVACY PRACTICES-SHORT FORM

Our practice is committed to educating our patients about healthcare issues that affect them. As a result, we are providing you with general information about Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) along with brief overview of our Notice of Privacy. Our practice is complying with HIPPA's regulations.

## What is HIPPA and how does the Privacy Rule affect you?

When the Health Insurance Portability and Accountability Act (HIPPA) was passed in August of 1996, this gave the federal government the ability to mandate how healthcare plans, providers, and clearinghouses store and send a patient's personal information as it relates to healthcare. The privacy rule was created to protect your rights as a patient of our practice, and we are required by law to be compliant with this regulation. Under the Privacy Rule you are guaranteed access to your medical records, allowed control over how your protected health information is used and disclosed and allowed to take action if your privacy is compromised by following the practice's policy. Our practice is dedicated to maintaining the privacy of your personal information.

## What is Individually Identifiable Health Information (IIHI)?

Any health information you provide our practice, including your mailing address. IIHI is any information that is created and retained by our practice or received by another healthcare provider that relates to treatment, payment, and/or that identifies you as an induvial.

## What is the Notice of Privacy Practice?

Our practice has an official Notice of Privacy Practice posted in our waiting room informing our patients about their rights surrounding the protection of your IIHI and our obligations concerning the use and disclosure of your IIHI. This notice applies to all records created or retained by our practice. We can update our Notice of Privacy Practices at any time. It will be posted, and a copy is provided in our waiting room and you can take a copy of the current notice at any time.

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The following categories describe the different ways in which we may use and disclose your IIHI:

Treatment	Appointment Reminders	Release of Information to Family/Friends		
Payment	Treatment Options	Disclosure Required by Law		
Health Care Operations	Health-Related Benefits and Services			
The following categories describe the different ways in which we may use and disclose your Identifiable Health Information:				

Public Health Risks	Health Oversite Activities	Lawsuits and Similar Proceedings
Law Enforcement	Deceased Patients	Organ and Tissue Donation
Serious Threats to Health or Safety	Research	Military
National Security Inmates	Workers' Compensation	

# What are your rights concerning your individually Identifiable Health Information (IIHI)?

What have rights regarding the IIHI that we maintain with you. In our Notice of Privacy, you can view the policies and procedures you will need to follow for the areas listed below.

1. Confidential Communications

- 2.Requesting Restrictions
- 3.Inspection and Copies

4.Amendment

5.Accounting of Disclosures
6.Right to a Paper Copy of this Notice
7.Right to file a complaint
8. Right to provide and Authorization for other uses and disclosures
If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer.
I have read the short notice provided by East Florida Premium Medical Care and have been informed of how to obtain more
information regarding our Notice of Privacy.

Patient's signature

Date

Print Name of Patient

## AUTHORIZATION FOR RELEASE OF INFORMATION

## Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identification health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

This form must be completely filled out

Patient Name		Last 4 digits of SSN #: XXX- XX-
Phone Number:		DOB:
Medical Provider to re	elease records:	
		Persons/organizations receiving the information:
		East Florida Premium Medical Care
		7421 N. University Drive, Suite 314 Tamarac FL 33321- 2977
		PHONE: (954) 724-3440 FAX (954) 724-3494
Specific description of	information (including o	ate(s)):
<pre>DatesCorrespondenceConsultations</pre>	<pre>Progress NotesHospital RecordsEntire Chart</pre>	LabsOperative ReportsRadiology ReportsTest ResultsOther Provider RecordsPT notesBillingRadiology FilmsOther

# Section B: Must be completed if only if a health plan or health care provider has requested the authorization.

- \* Will the health plan or care provider requesting the authorization received the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? \_\_\_\_ YES \_\_\_\_ NO
- \* I understand that my health care and the payment for may health care will no be affected if I do not sign this form.
- \* I understand that I may see and copy the information described on this form if I ask for it, and that I et a copy of this form after I sigh it. Further, I understand there may be a fee for a copy of this information
- \*

# Section C: Must be completed for all authorizations

- \* What is the purpose of the use or disclosure? \_\_\_\_\_
- \* I understand that authorization will expire on \_\_\_/\_\_\_. Or at the term of \_\_\_\_\_\_ event. If not specified, this release will expire 180 days from the date signed.
- \* I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions they took before they received the revocation.
- \* I understand that my records are protected under state and federal law. I understand that specific information to be disclosed may include history of drug or alcohol abuse, mental health treatment, AIDS or any other medical information.

Signature of Patient or Patient's Representative (Form must be completed before signing)

\_\_\_\_\_

Printed name patient's representative: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

\*\* YOU MAY REFUSED TO SIGN THIS AUTHORIZATION \*\*