Heart Care Centers of Florida

PRIVACY NOTICE ACKNOWLEDGEMENT

Purpose: This form is used to document (a) an individual's acknowledgement of receipt of our Privacy Practices Notice or (b) when we have not obtained this acknowledgement, our good faith effort to obtain the acknowledgement.

Patient Name: _____

Medical Record Number: _____ Social Security Number: _____

Date of Admission: _____ Notice Version (Date): _____

Acknowledgement of receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Privacy Practices Notice from:

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and health care operations as discussed in the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

☐ Notice has previously been distributed by another location in our OHCA (except for physicians):

List location that distributed the Joint Notice: _____

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

IF NOT SIGNED: (Good faith effort to obtain acknowledgement of receipt)

Describe your good faith effort to obtain the individual's signature on this form: _____

Describe the reason why the individual would not sign this form: _____

Additional Disclosure Authority:

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

Spouse: _____

Other: _____

SIGNATURE: (Office Representative)

I attest that the above information is correct.

Signature: _____ Date: _____

Print name: _____ Title: _____

Include this acknowledgement form in the individual's records.

Heart Care Centers Of Florida

There is a **$20** fee for any form (Disability, Life, Insurance, Etc…) to be filled out. Payment must be made at the time the form is dropped off. Please allow **10** business days for the form to be filled out, faxed, or picked up. We will not fill out forms prior to your surgery date.

Thank You

Patient Signature: _____ Date: _____

Heart Care Centers of Florida
AUTHORIZATION FOR RELEASE, USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Fax Number: _____

☐ **Access Request to Copy/Inspect**

I authorize the use/disclosure of health information about me as described below:

1. The following organization is authorized to make the disclosure:

   _____
   Name of Facility

   _____
   Address

2. The type of information to be used or disclosed is as follows (please include dates of service)
   Date(s) of Service: _____

   ☐ Complete Medical Record
   ☐ Abstract of Medical Record (H&P, Discharge Summary, Consultation Reports, Operative & Procedure Reports, EKGs, Laboratory, X-ray and imaging reports)
   ☐ History & Physical (H&P)
   ☐ X-ray and imaging reports
   ☐ Discharge Summary
   ☐ Progress Notes
   ☐ Operative Report
   ☐ Laboratory Test Results
   ☐ Consultation Reports
   ☐ Immunization Record
   ☐ Other- list specific Items: _____

   Behavioral Health Reports:
   ☐ Social History
   ☐ Treatment Plan
   ☐ Client Data Form
   ☐ Academic History
   ☐ Referral/Treatment Form
   ☐ Aftercare Instructions
   ☐ Admission Evaluation
   ☐ Psychological Evaluation
   ☐ Notification of Admission
   ☐ Other – list specific items: _____

3. I understand that 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, treatment of alcohol abuse and substance abuse.

   This information is being provided to you from records whose confidentiality may be protected by State and/or Federal law.

4. I understand that your facility may receive compensation for medical record copying in accordance with State law.

5. This information may be disclosed to and used by the following individual/organization: (Information will be faxed to providers only for medical care purposes)

Name: _____

Address: _____

Phone: _____ Fax: _____

For the purpose of:

☐ Further Medical Care
☐ Inspection/Copying of my records
☐ Personal
☐ Other (please specify):_____
☐ Insurance Eligibility/Benefits
☐ Legal Investigation or Action
☐ Changing Physicians

6. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you or your business associates maintain. I understand however I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, (42 U.S.C. section 263 (a), and certain other records.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed under this authorization as described in #6 above.

8. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of this authorization.

9. I understand that I may revoke this authorization in writing at any time. To 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. **This authorization expires within 90 days, unless otherwise specified.**

_____ _____
Signature of Patient Date

(If signed by someone other than the patient, indicate relationship and authority to do so.)

_____
Name of Patient (Please Print)

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Custodial Parent ☐ Legal Guardian ☐ Executor of Estate of Deceased
☐ Power of Attorney for Health Care ☐ Authorized Legal Personal Representative

_____ _____
Signature of Witness Date

FOR WUESTHOFF USE ONLY:

MR #: Acct: #	_____ _____	Patient ID Verification	Employee Initials: Date:	Information Released by: □ Fax □ Mail □ Given to hand carry to provider □ Not release/Other (specify): _____

Wuesthoff Health System, Inc
Authorization for Release, Use and
Disclosure of Health Information

HIPAA Form 3, Version 1, Authorization 10/1/10 ,
Revised 1/14/11 hrp

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