ZEIDERS
orthopedics

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PATIENT HIPPA FORM

Patient Name: _____

Date of Birth: _____ Today's Date: _____

Notice of Privacy Practices Acknowledgement

_____ (PATIENT) I acknowledge that I have received Zeiders Orthopedics Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for it treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated in the office if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Zeiders Orthopedics Notice of Privacy Practices.

Release of Information

_____ (PATIENT) I permit the practice and the physician or other healthcare professionals involved in the inpatient or outpatient care to release healthcare information for the purposes of of treatment, payment or healthcare operations.

- Healthcare information regarding a prior admission(s) at other facilities may be made available to subsequent affiliated admitting facilities to coordinate patient cate for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, Physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit the facility to participate in organizations with other healthcare providers, insurers, and/or health care industry participants and their subcontractors in order for these individual and entities to share my health information with one another to accomplish goals that may include but not limited to: improving the accuracy and increasing the availability of my health records; decreasing the tome needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to: blood born disease, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Disclosures to Friend and/or Family Members

I give my permission to for my Protected Health Information to be disclosed for purposes of communicating results, finding and care decisions to the family members and other listed below:

Name 1 _____
Name 2 _____
Name 3 _____

Authorized Signature: _____ Date: _____

Print name of person signing if other than the patient: _____ Relationship: _____