Authorization to Release Medical Records

Please complete the following information:

Patient Name: _____
Address: _____
_____
Phone: _____
SSN: _____Date of Birth:_____/_____/_____

I authorize the custodian of records of: or other person/entity (specifically describe) to disclose/release the following information

- ☐ All records
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient and date

_____ _____
Printed name of patient representative Representative's authority to sign for patient, *(i.e parent, guardian)*

FLORIDA
SPORTS INJURY
& ORTHOPEDIC INSTITUTE

Please complete the following information:

Insurance Authorization and Assignment: I hereby assign, to Florida sports injury and Orthopedic Institute, payment of medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.

Financial agreement: I understand I will be legally responsible for all charges whether or not they are covered by my insurance as well as any co-payment and coinsurance. In the event of non-payment for any of these costs, I understand I will be legally responsible for all costs involved with the collection of this account including all court costs, attorney fees, and any expenses incurred, should this be required.

Consent to Treat: I requested and gave consent to my physician to provide and perform such medical surgical care, tests, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well-being. I acknowledge that no representations, warranties or guarantees as to the result or cures have been made to me or relied upon by me.

Medicare Certification: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Florida sports injury and Orthopedic Institute for any services furnished by my physician. I authorize any holder of medical information about me to release the Healthcare Financial Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payments be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of the Medicare carriers.

_____ _____
Signature of patient and date

_____ _____
Printed name of patient representative Representative's authority to sign for patient, *(i.e parent, guardian)*

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PATIENTS BILL OF RIGHTS AND RESPONSIBILITIES:

The staff of this health care facility recognizes you have rights while a patient receiving medical care. In return, there are responsibilities for certain behavior on your part as the patient. These rights and responsibilities include:

- ✓ Be treated with courtesy and respect, with appreciation of this individual dignity and with protection of his need for privacy.
- ✓ A prompt and reasonable response to questions and requests.
- ✓ Know who is providing medical services and who is responsible for his care.
- ✓ Know what patient support services are available, including whether an interpreter is available if he does not speak English.
- ✓ Know what rules and regulations apply to his conduct.
- ✓ Be given, by his health care provider, information concerning diagnosis, a planned course of treatment, alternatives, risks and prognosis.
- ✓ Know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- ✓ Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- ✓ Receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have charges explained.
- ✓ Impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical disability or source of payment.
- ✓ Treatment for any emergency medical condition will deteriorate from failure to provide treatment.
- ✓ Know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research.
- ✓ Express concerns regarding any violation for patient rights.

A patient is Responsible for:

- ✓ Providing to his health care provider, to the best of his knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relation to his health.
- ✓ Reporting unexpected changes in his condition to his health care provider.
- ✓ Reporting to health care provider whether he comprehends a contemplated course of action and what is expect of him.
- ✓ Following the treatment plan recommended by his health care provider.
- ✓ Keeping appointments.
- ✓ His actions if he refuses treatment or does not follow the health care providers instructions.
- ✓ Assuring that the financial obligations for his health care are fulfilled as promptly as possible.
- ✓ Following health care facility rules and regulations affecting patient care and conduct.

COMPLAINTS:

If you have a question or concern about your rights or responsibilities, please let us know. We want to assure that we provide you with excellent service, including answering your questions and responding to your concerns.

Please read Florida Sports Injury and Orthopedic Institute HIPAA Privacy Notice and complete the steps at the bottom of the page.

HIPAA Privacy Notice

THIS NOTICE DESCRIBED HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Privacy Notice is being provided for you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice described how we may use and disclose your protected health information to carry-out treatment, payment or health-care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.

Uses and Disclosures of Protected Health Information

Florida Sports Injury and Orthopedic Institute may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the facility has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

A. Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose protected health information to physicians who may be treating you or consulting with the facility with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. Payment. Your protected health information will be used as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the surgery. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers for payment of their services.

C. Operations. We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of Florida Sports Injury and Orthopedic Institute and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities, employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.

In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. Other Uses and Disclosures. As part of treatment, payment and health care operations, we may also use or disclose your protected health

information for the following purposes: to remind you of your surgery date, to inform you of potential treatment alternatives or options, to inform you of health-related benefits or services that may be of interest to you, or to contact you to raise funds for the facility or an institution foundation related to the facility. If you do not wish to be contacted regarding fundraising, please contact our Privacy Officer.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. When Legally Required. We will disclose your protected health information when we are required to do so by any federal, state, or local law.

B. When There Are Risks to Public Health. We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

C. To Report Suspended Abuse, Neglect Or Domestic Violence. We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specfically required or authorized by law or when the patient agrees to the disclosure.

D. To Conduct Health Oversight Activities. We may disclose your protected health information to an health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. In Connection With Judicial And Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. For Law Enforcement Purposes. We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Pursuant to court order, court-ordered warrant, supoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- In an emergency to report a crime.

G. To Coroners, Funeral Directors, or for Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medial examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

H. For Research Purposes. We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. In the Event of a Serious Threat to Health or Safety. We may, consistent with applicable law and ethical standards or conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and

imminent threat to your health or safety or to the health and safety of the public.

J. For Specified Government Functions. In certain circumstances, federal regulations authorize the facility to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

K. For Worker's Compensation. The facility may release your health information to comply with worker's compensation laws or similar programs.

III. Uses and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your protected health information to your family member or close personal friend if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interest for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures which you Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

V. Your Rights

You have the following rights regarding your health information:

A. The right to inspect and copy your protected health information. You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your surgeon and the facilities uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the bottom of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

B. The right to request a restriction on uses and disclosures of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to who you want the restriction to apply.

The facility is not required to agree to the restriction that you may request. We will notify you if we deny your request to a restriction. If the facility does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. The right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. The right to request amendments to you protected health information. You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Requests for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendments.

E. The right to receive an accounting. You have the right to request an accounting of certain disclosures of your protected health information made by the facility. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclsures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. The right to obtain a paper copy of this notice. Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

VI. Our Duties

The facility is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to chance the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the facility changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact.

VII. Complaint

You have the right to express complaints to the facility and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the facility by contacting the facility's Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Contact Person

The facility's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this facility you may submit a complaint to our Privacy Officer by sending it to:

Florida Sports Injury and Orthopedic Institute
1925 Don Wickham Drive
Clermont Florida 34711

IX. Effective Date

This Notice is effective 08/20/2011

IF YOU HAVE ANY QUESTION CONCERNING OUR HIPAA PRIVACY NOTICE OR WE CAN ASSIST YOU IN ANY WAY, PLEASE FEEL FREE TO CALL ON OUR OFFICE STAFF.

When you have read the HIPAA Privacy Notice, please click the checkbox and fill in your initials.

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

SSN: _____ DOB: _____

ADDRESS: _____

_____

PHONE: _____(home) _____ (work) _____ (cell)

(initial below)

_____ I have read and understood Florida Sports Injury and Orthopedic Institute HIPAA Privacy Notice.