Parkcrest Orthopedics
Specialist in Upper Extremities
James P. Emanuel MD, CIME

H.I.P.A.A. Notice & Protected Health Information Disclosure Permission

PATIENT NAME: _____ DOB: _____

Parkcrest Orthopedics will not disclose your Protected Health Information (PHI) to anyone other than those permitted by the HIPAA Privacy Rule. The HIPAA Privacy Rule permits us to disclose your PHI to your insurance company and/or other healthcare providers.

You have the option to permit access of your protected health information to any other individuals by listing their names below.

In the event that someone calls our office on your behalf to ask questions concerning your PHI, or shows up at our office on your behalf to pick up a prescription, we will not release any of your information to that individual unless his/her name is listed below.

We do not require it, but we do recommend you list at least one trustworthy individual such as a spouse, family member, neighbor, attorney, etc.

NAME RELATIONSHIP TO PATIENT

_____

_____

_____

_____

_____

This authorization is given freely with the understanding that this authorization is valid until revoked by law. I may revoke this authorization at any time, except where information has already been released. Individuals not listed on this form will be unable to receive any information. Parkcrest Orthopedics and its workforce are hereby released from any legal responsibility or liability for disclosure of any of my Protected Health Information as indicated and authorized herein.

NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information. I understand that Parkcrest Orthopedics, LLC may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization. Parkcrest Orthopedics, LLC has a detailed document called the *'Notice of Privacy Practices'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information. I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Parkcrest Orthopedics, LLC will provide me with the most current *Notice of Privacy Practices*. My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Parkcrest Orthopedics, LLC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Parkcrest Orthopedics, LLC has taken action relying on this consent.

How would you like to receive your appointment reminders? Check all that apply. Texting is unavailable. *By providing the below information, you are granting permission to be contacted for appointment reminders.*

☐ Call/leave me a voicemail. My phone number is: (_____)_____.
☐ Email them. My email address is: _____.

By signing below, I attest that I have read & understand the above policies of Parkcrest Orthopedics, & accept my responsibility as stated in those policies. I authorize release of information necessary for my insurance company to process my claim. I authorize Parkcrest Orthopedics to contact me for appointment reminders as described above.

_____

PATIENT'S SIGNATURE (OR PARENT OR LEGAL GUARDIAN IF A MINOR) DATE