SOUTHEASTERN LUNG CARE
THE SLEEP DISORDERS CENTERS OF SOUTHEASTERN LUNG CARE

Patient Name: _____ DOB: _____ ACCT#: _____

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plan, providers, individual, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

I understand that I have read the "Notice of Information Practices" that provides a more complete description of information uses and disclosures, posted in the lobby reception rooms. I understand that upon request I will be provided a copy of such notice. It is our policy to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. (Except appointment reminders, leaving date, time and doctor's name only) Whenever returning phone calls and the answering machine picks up, we will only leave our name and number if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer the phone.

If you would like to have information released to someone other than yourself please complete the following:
I authorize Southeastern Lung Care and The Sleep Disorders Centers of Southeastern Lung Care to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:
(PLEASE FILL THIS OUT COMPLETELY, IT TELLS US HOW TO CONTACT YOU.)

Home telephone # _____	Yes _____	No _____	Answering Machine	Yes _____	No _____
Work telephone # _____	Yes _____	No _____	Voice mail	Yes _____	No _____
Cell phone/Voice mail #_____	Yes _____	No _____	Pager #_____	Yes _____	No _____
Can we fax medical records for referrals?	Yes _____	No _____	Postal Service	Yes _____	No _____

Please list names of people we can discuss your medical care with:
Spouse: _____ Yes _____ No _____ Phone #_____
Parent: _____ Yes _____ No _____ Phone #_____
Other: _____ Relationship: _____ Phone # _____

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, Southeastern Lung Care and The Sleep Disorders Centers originate and maintain health records describing my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
- A source for determining participation in/qualification for research studies

Special Situations: We may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness. We may disclose medical information about you for public health activities such as to prevent or control disease, injury, disability and driving etc.

I understand that the *Notice of Information Practices* provides a more complete description of Information uses and disclosures and that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices. I understand that I have the right to object to use of my health information for director purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

I would like to be provided with a copy of the Notice of Information Practices: (please mark one) □ Yes □ No

_____ _____
PATIENT/GUARDIAN SIGNATURE **ORIGINAL DATE**

_____ _____
WITNESS SIGNATURE **UPDATED ON:**

TELEPHONE AUTHORIZATION IN PATIENT'S ABSENCE: **EMPLOYEE SIGN:** _____ **WITNESS SIGN:** _____