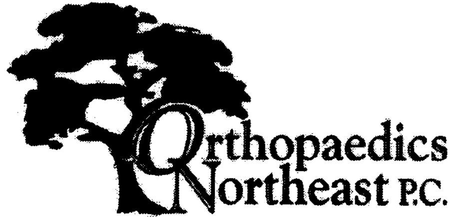


**HIPAA FORM**
**FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION**
**OFFICE POLICY DISCLOSURE FORM**
**MEDICATION HISTORY AUTHORITY**

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Name of Patient:_______________________________

Social Security Number:__________________________

Date of Birth:___________________________________

By signing this HIPAA Form, I acknowledge that I have received the Notice of Privacy Practices and:

1. I am aware that Orthopaedics Northeast, P.C. must use and disclose my identifiable health information for the following purposes and activities:

Treatment (including, but not limited to, disclosures necessary for consultations with and/or referrals to other providers, the coordination of the provision of care, and the scheduling of care. This includes disclosures to the Radiology Scheduling Line.)

Health Care Operations (including but not limited to disclosures necessary for conducting quality assessment and improvement programs, care coordination, evaluating provider performance, conducting provider training programs, and business management and administrative activities or Orthopaedics Northeast, P.C.)

2. I understand that the health information disclosed may include sensitive information relating to the patient's HIV/AIDS status, drug or alcohol abuse, mental or behavioral health and/or psychiatric history, unless a specific request is received from the patient in writing to not include this information.

3. By signing this form, I give authorization to Orthopaedics Northeast to access my medication history. I also give permission to contact me by phone, and electronic means including automated calls, and text messages if applicable.

4. I understand that I am financially responsible for payment of copays and any amounts not covered by my insurance. This would include balances if I fail to obtain a referral, deductibles and/or coinsurances. If I default on payment of my financial obligation, I understand that I would then be responsible for any collection fees that would arise out of attempts to collect on these delinquent balances.

Signature of patient or patient's representative:_______________________________

Date:_______________________________

Printed name of patient's representative:_______________________________

Relationship to patient, giving representative authority to act for patient:_______________________________