HIPAA AUTHORIZATION

MRN: _____ **DATE:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please answer the following questions regarding disclosures that occurs as a part of our normal office operations

May we leave Automated Messages…

for appointment reminders? ❑ yes ❑ no
for "Normal" result messages? ❑ yes ❑ no
for Health Maintenance messages? ❑ yes ❑ no
for RX Refill notifications? ❑ yes ❑ no
for General Notifications? ❑ yes ❑ no

Preferred number? ❑ Home ❑ Cell ❑ Work

I, _____,
full name
hereby authorize the use and detailed disclosure of my protected health information under the federal health privacy law (HIPAA) to the following persons/places:

	Type of Disclosure		
	Medical	Financial	Scheduling
Name: Relationship: Phone #	❑	❑	❑
Name: Relationship: Phone #	❑	❑	❑
Name: Relationship: Phone #	❑	❑	❑
Name: Relationship: Phone #	❑	❑	❑

Prescription History

May we obtain your prescription history from your for pharmacy/RX Hub? ❑ yes ❑ no

Medical/Financial/Insurance Issues

If we reach a voice mail or anyone other than you when calling regarding these issues, what type of message may we leave?

Home Phone ❑None ❑ Brief ❑ Detailed
Cell Phone ❑None ❑ Brief ❑ Detailed
Work Phone ❑None ❑ Brief ❑ Detailed

EXAMPLES

brief: *"Please call regarding your lab results"; "your prescription has been called into your pharmacy"*

detailed: *"Your CBC was 24"; "Prednisone 2.5 called to Walgreens*

*If you would prefer **NOT** to be contacted by phone, how would you like contacted regarding medical issues?*

Who has permission to pick up your prescriptions?

If you qualify, may we contact you regarding participation in clinical trials? ❑ yes ❑ no

For access to your health records online, please provide your email address:

HIPAA AUTHORIZATION

I understand that Piedmont Arthritis Clinic will disclose health information to my insurance company upon their request for the purpose of payment or to authorize treatment. They will also send the necessary medical information to facilitate my care upon referral to another physician or for testing. For further information, I will refer to their Notice of Privacy Practices or request to speak to their Privacy Official. I also understand that if the above person or entities receiving this information are not a covered by federal privacy regulations, the released information might be re-disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may revoke or change this authorization at any time by notifying Piedmont Arthritis Clinic in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Piedmont Arthritis Clinic before receiving my revocation.

SIGNATURE: **DATE:**

INSURANCE INFORMATION

Primary Insurance Name: _____
ID#: _____
Co-pay $_____ Deductible $_____ then _____ %
Policy Holder Name: _____
SS#: _____
Employer (policy holder): _____
Date of Birth: _____

Secondary Insurance Name: _____
ID#: _____
Co-pay $_____ Deductible $_____ then _____ %
Policy Holder Name: _____
SS#: _____
Employer (policy holder): _____
Date of Birth: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I understand that I am financially responsible for charges incurred by myself or any dependent if my insurance company denies payment for any reason. I understand that any financial responsibility on my part will be paid in full upon receiving a bill (unless financial arrangements have been made). I hereby assign all benefits to be paid directly to my rendering physician. This assignment includes any treatment within a hospital/facility setting. I hereby authorize Piedmont Arthritis Clinic to provide any identifiable health information to my insurance carrier for the necessity of processing insurance claims.

SIGNATURE: **DATE:**