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PATIENT DISCLOSURE FORM FOR HEALTH CARE INFORMATION

FACILITY: BAY FAMILY CARE CENTER, LLC

The Health Insurance Portability & Accountability Act of 1996(S160.103)

Defines individual health information as information, including demographic information collected from an individual and:
(1) Created or received by a healthcare provider, health plan, employer, or healthcare clearing house, and
(2) Relates to the past, present, or future physical or mental health or condition of individual; the provision of healthcare to an individual; or the past, present or future payment for provision of health care to an individual, and
(3) The information therefore identifies an individual or provides a reasonable basis to believe the information can be used to identify the individual.

Permitted disclosure (S164.502) and uses by a health care provider include:
(1) For treatment, payment of health care operations as permitted under this law
(2) Uses for disclosure to personal representative assigned by the patient
(3) Disclosure to the parents or persons acting in loco parentis to an un-emancipated minor
(4) For case management or care coordination for the individual or to direct or recommend alternative treatments, therapies, health care providers, healthcare settings.

NAME OF PATIENT:________________________________DATE:____________

I ______________________________am a patient/and or the guardian/parent of _________________________. I understand that I am required to inform BAY FAMILY CARE CENTER, LLC of the persons to whom they may disclose my medical information. These assigned persons may be changed at any time. This disclosure is effective ____________ and will continue for one year thereafter. This facility has provided me with a list of all the person and agencies, or payers to whom my medical information may be disclosed during the course of any medical treatment by this facility. I HAVE READ THE PERMITTED DISCLOSURE FORM AND ASSIGN THE FOLLOWING:

TRUSTEE: (Family member, lawyer, other who can access my medical information)

Name of Trustee: ____

Phone:________________ Address:____

Name of Trustee: ____

____ Initial - Acknowledgement receipt of Privacy Practices Rev. 11/30/04

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