Acknowledgement of Review of Notice of Privacy Practices (HIPAA) and Authorization for Release of Your Medical Record

TO OUR PATIENTS: We are required by all applicable federal and state laws to maintain the privacy of your health information. We may use or disclose your health information to a physician or other health care provider that provides treatment to you.

We may use and disclose your health information to obtain payment from insurance companies or third parties for treatment and services we provide to you, unless notified in writing that you do not want us to disclose your health information to your insurance provider, in which case you would be a self-paying patient and would be responsible for paying your claims out-of-pocket.

Please **initial and check** how we will process your claims at the Family Medicine Associates of El Paso, P.A.:

☐ I choose to use my Insurance Provider for processing of my claims.

Initials: _____.

☐ I choose NOT to use my Insurance Provider, and the services rendered from Family Medicine Associates of El Paso, P.A. will be paid out-of-pocket.

Initials: _____.

We **may** disclose your health information:

- To our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services.
- To oversight activities which include audits, investigations, inspections and licensure.
- For Data Breach Notification purposes to provide legally required notices of unauthorized access to your health information.
- For lawsuits and disputes.
- To any of the following entities or for the purposes mentioned: law enforcement; coroners, medical examiners and funeral directors; protective services for the President and others; public health risks; health oversight activities permitted by law; national security and intelligence activities; if you are an inmate or individual in custody.

UNLESS YOU GIVE US WRITTEN AUTHORIZATION, WE CANNOT USE OR DISCLOSE YOUR HEALTH INFORMATION FOR ANY REASON EXCEPT THOSE DESCRIBED ABOVE.

We **may not** disclose your health information without written authorization for the following:

1. **USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES.**

   ☐ By checking this box and signing below, I authorize Family Medicine Associates of El Paso, P.A. to send me educational and/or marketing information on new products and services that may become available. Family Medicine Associates of El Paso, P.A. may receive direct or indirect remuneration from another entity for participating in certain educational and/or marketing events or promotions.

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Please **initial and check** how we may disclose your health information:

☐ I ALLOW my protected health information to be used for Marketing Purposes.
Initials: _____.

☐ I DO NOT ALLOW my protected health information to be used for Marketing Purposes.
Initials: _____.

2. **DISCLOSURES THAT CONSTITUTE A SALE OF YOUR PROTECTED HEALTH INFORMATION.**

****If for any reason you are unable to sign a medical release for your medical records, you may state in writing (below) a person's name and information allowing them to communicate or sign and pick up your protected health information (e.g., a family member, spouse or friend that you trust). If you do not provide the name of a contact in the space below, we will understand that you do not want anyone to be able to pick up your medical records for you. ****

Name: _____

Address: _____

Telephone: _____

Fax: _____

I understand that Family Medicine Associates of El Paso, P.A. has permission to release and discuss my information to the person(s) stated on this form, and that I can change at any time to allow/disallow another person to receive my information if so desired, but this must be stated in writing. If no one is listed above, records will be released to no one but the patient.

A signature (below) is required to acknowledge your understanding of Family Medicine Associates of El Paso, P.A.'s Privacy Practices.

_____ _____
Signature of patient (or patient's representative) Date

_____ _____
Printed name of patient or representative Representative's authority to sign for patient (e.g., parent, guardian, power of attorney for health care, or executor.)

HIPAA Updated as of 2/15/2017