East Texas Family Medicine

Please complete and return to the office prior to your appointment. Today's Date: _____

Name: Last: _____, First: _____ MI: ___ Nickname: _____

Date of Birth: _____ Age: _____ Sex: M F SSN: _____

Parent/Legal Guardian (if the patient is a minor):

Name: Last: _____, First: _____ Relation: _____

Date of Birth: _____

Phone: Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Please initial if it is alright to leave a detailed message with health information on your voicemail: _____

Home Address:

_____

Street City State Zip

If married, please provide the following spouse information:

Name: _____ Date of Birth: _____

Address: ☐ Same as above or

_____

Street City State Zip

Emergency Contact: ☐ Same as parent/guardian or _____ Relation: _____

Phone: (_____) _____ Alternative Phone: (_____) _____

Address: ☐ Same as above or

_____

Street City State Zip

Please list any persons you authorize the clinic to leave personal medical information with: (optional)

Name: _____ Relation: _____

Name: _____ Relation: _____

Primary Insurance: _____ **Secondary Insurance:** _____

Subscriber Name: ☐ Self or _____ Subscriber Name: ☐ Self or _____

Subscriber Date of Birth: _____ Subscriber Date of Birth: _____

Subscriber SSN: _____ Subscriber SSN: _____

Signature: _____ **Date:** _____

East Texas Family Medicine

Patient Name: _____ DOB: _____ Today's Date: _____

Past Medical History and Family History

Last Annual Wellness Exam: _____

Most Important Concerns for this visit: 1. _____

2. _____

ALLERGIES to Medication: ☐ **Yes (detail below)** ☐ **No Known Drug Allergy**

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Other Allergies (please list): _____

MEDICATIONS: Please list all prescriptions and over-the-counter medications:

Prescriptions:

Medication	Dose	Instructions

(For additional items, please continues on back of this sheet)

Over-the-Counter Medications (non prescription):

Medication	Dose	Instructions

Supplements: Please list all herbal preparations and supplements that you take on a daily basis

Description	Amount taken daily

Preferred Pharmacy

Name: _____

Address: _____
Street City State Zip

Phone: (____) _____

East Texas Family Medicine

Patient Name: _____ DOB: _____ Today's Date: _____

Do you have advanced directives? (Living Will, Durable Power of Attorney for medical decisions) ☐ Yes ☐ No

Please list other physicians and health care providers you see (specialists, therapists, counselors, chiropractors, etc):

Provider_____ Reason _____
Provider_____ Reason _____
Provider_____ Reason _____
Provider_____ Reason _____

PAST MEDICAL HISTORY: Please describe any condition that you have yourself:

Condition (Check all that apply)	**Details (Year of Diagnosis, etc)**
☐ Eye Disease or Cataracts	
☐ Lung Disease	
☐ Heart Disease	
☐ Cancer	
☐ Depression/Anxiety	
☐ Mood Disorder	
☐ Diabetes	
☐ Digestive/stomach/GERD	
☐ Bleeding or Clotting Disorders	
☐ Hypertension	
☐ Elevated Cholesterol	
☐ Kidney Disease	
☐ Sleep Apnea	
☐ Thyroid Disease	
☐ Other: _____	

Previous Surgeries

Surgery	**Details (Date, Complications, etc)**

Other Hospitalizations (include year and reason for admission:

_____

_____

East Texas Family Medicine

Patient Name: _____ DOB: _____ Today's Date: _____

FAMILY MEDICAL HISTORY:

Father's Health Conditions: _____

Living? Y N If no, age of death _____

Mother's Health Conditions: _____

Living? Y N If no, age of death _____

Sibling's Health Conditions: _____

Other: _____

_____

PERSONAL & SOCIAL HISTORY:

Do you smoke?

- ☐ No, I have never smoked.
- ☐ Yes, I smoke ___ packs of cigarettes a day for ___ years.
- ☐ No, I quit smoking ___ years ago. I smoked ___ packs a day for ___ years.
- ☐ Yes, I smoke cigars or a pipe, ___ a day for ___ years.
- ☐ Yes, I use smokeless tobacco ___ times a day for ___ years.

Describe current dietary limitations: _____

Who lives with you? _____

Occupation (indicate if retired): _____

Foreign travel outside of the U.S. in the past year _____

Additional information you would like for us to know about your health:

_____

_____

_____

Previous Primary Care Physician: _____

Please tell us if you have had any of the following screening tests, and the most recent date:

Colonoscopy: _____

DEXA (bone density): _____

Women: Pap: _____ Mammogram: _____

Adult Immunizations:

Tetanus	☐ Yes ☐ No	Date:_____	Was pertussis included (Tdap)? ☐ Yes ☐ No
Pneumonia	☐ Yes ☐ No	Date:_____	
Hepatitis B	☐ Yes ☐ No	Dates (3 shots): _____	
HPV	☐ Yes ☐ No	Dates (3 shots): _____	
Zostavax	☐ Yes ☐ No	Date: _____	

East Texas Family Medicine

Patient Name: _____ DOB: _____ Today's Date: _____

Review of Systems (Current health symptoms):

1.	Have you had a recent **weight gain or loss** that worries you?	☐ Yes ☐ No
2.	Have you had any **unexplained fevers or night sweats?**	☐ Yes ☐ No
3.	Do you have **sinus or nasal allergy symptoms** that affect your quality of life?	☐ Yes ☐ No
4.	Do you have any **vision or hearing problems** that are bothersome?	☐ Yes ☐ No
5.	Are you experiencing **chest pains or irregular beats** that worry you?	☐ Yes ☐ No
6.	Do you have unusual **shortness of breath or a persistent cough?**	☐ Yes ☐ No
7.	Do you have **leg swelling** that is recurrent or bothersome?	☐ Yes ☐ No
8.	Do you experience **wheezing** when you breathe?	☐ Yes ☐ No
9.	Do you have **sleep problems** that interferes with your quality of life?	☐ Yes ☐ No
10.	Have you been told that you **snore and stop breathing during sleep?**	☐ Yes ☐ No
11.	Do you have **constipation, diarrhea, stomach pain,** or other problems with digestion that interfere with your quality of life?	☐ Yes ☐ No
12.	Have your **bowel movement patterns** changed in the recent months?	☐ Yes ☐ No
13.	Do you have **problems with urination** that affect your quality of life?	☐ Yes ☐ No
14.	Do you have **joint or back problems** that affect your quality of life?	☐ Yes ☐ No
15.	Do you have **leg pain, numbness, or weakness** that limits how fast or far you can walk?	☐ Yes ☐ No
16.	Do you have **headaches** that affect your ability to function?	☐ Yes ☐ No
17.	Have you had an **unexpected fall with injury** in the past year?	☐ Yes ☐ No
18.	Do you have **little pleasure** in your daily activities?	☐ Yes ☐ No
19.	Do you feel **depressed or hopeless?**	☐ Yes ☐ No
20.	Are you concerned about **anxiety or stress** in your life?	☐ Yes ☐ No
21.	Are you concerned about your **memory?**	☐ Yes ☐ No

Comments: _____

_____

_____

Note: Evaluation of these concerns is not usually part of an annual wellness or preventative exam. It is likely that your doctor will need to schedule extra time or an additional appointment to follow up on these concerns.

Notice of privacy practices
Effective date: August 1, 2013

East Texas Family Medicine
206 Gene Samford Dr. Ste. B
Lufkin, TX 75904

Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (*also called protected health information, or PHI*). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact Katy Johnson, Office Manager and HIPPA officer.
C. The manner(s) in which we may use and disclose your PHI:
The following categories describe the different ways in which we may use and disclose your PHI.
1. Treatment: Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. Payments: Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose you PHI to obtain payment from third parties that may be responsible for such costs, such as family members, employers or other guarantors. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations: Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost management and business planning protocol for our practice. We may disclose you PHI to other health care providers and entities to assist in their health care operations.
4. Appointment reminders: Our practice may use and disclose your PHI to contact you and remind you of an appointment. We may leave appointment reminders on your answering machine or with a family member or other person who may answer the telephone at the contact number(s) you provide us.
5. Treatment options: Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. Health-related benefits and services: Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.
7. Release of information to family/friends: Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the doctor's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
8. Disclosures required by law: Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

D. Use and disclosure of your PHI in certain special circumstances:
The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks: Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
    - Maintaining vital records, such as births and deaths,
    - Reporting child abuse or neglect,
    - Preventing or controlling disease, injury, or disability,
    - Notifying a person regarding potential risk for spreading or contracting a disease or condition,
    - Reporting reactions to drugs or problems with products or devices,
    - Notifying individuals if a product or device they may be using has been recalled,
    - Notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
    - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
2. Health oversight activities: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and similar proceedings: Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party requested.
4. Law enforcement: We may release PHI if asked to do so by a law enforcement official:
    - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
    - Concerning a death we believe has resulted from criminal conduct,
    - Regarding criminal conduct at our offices,
    - In response to a warrant, summons, court order, subpoena or similar legal process,
    - To identify/locate a suspect, material witness, fugitive or missing person,

- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased patients: Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
6. Organ and tissue donation: Our practice may release PHI to organizations that handle organ, eye or tissue and transplantation if you are an organ donor.
7. Research: Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:
    - The use or disclosure involves no more than a minimal risk to your privacy based on the following: (a) an adequate plan to protect the identifiers from improper use and discloser, (b) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (c) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;
    - The research could not practicably be conducted without the waiver,
    - The research could not practicably be conducted without access to and use of the PHI.
8. Serious threats to health or safety: Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. Military: Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. National security: Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.
11. Inmates: Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. Workers' Compensation: Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding you PHI: You have the following rights regarding the PHI that we maintain about you:
1. Confidential communications: You have the right to request that our office practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to East Texas Family Medicine specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. Requesting restrictions: You have the right to request a restriction in our use or disclosure of you PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of you PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your

PHI, you must make your request in writing to East Texas Family Medicine. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies: You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to East Texas Family Medicine in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. Amendment: You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to East Texas Family Medicine. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete, (b) not part of the PHI kept by or for the practice, (c) not part of the PHI which you would be permitted to inspect and copy, or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. Accounting of disclosures: All of our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment, or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented- for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an "accounting of disclosures", you must submit your request in writing to East Texas Family Medicine All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. Right to a paper copy of this notice: You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact East Texas Family Medicine.
7. Right to provide an authorization for other uses and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note: we are required to retain records of your care.*

Again, if you have any questions regarding this notice or our health information privacy policies, please contact East Texas Family Medicine HIPPA Officer.

Patient Agreement

Authorization for Medical Treatment

Office Practice/Clinic personnel at East Texas Family Medicine are hereby authorized to administer any medical diagnostic or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstance.

Disclosure of Information

I understand that my medical records and billing information are made and retained by this Office Practice and Billing/Clinic and are accessible to office personnel. Office Practice Billing/Clinic personnel may use and disclose medical information for operations, functions, and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. This Office Practice Billing/Clinic and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, workers' compensation carrier, or self-insured employer group liable for any part of the Office Practice/Clinic's charges and to my health care provider who is or may become involved with my care. Texas law requires that this Office Practice/Clinic advises you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including but not limited to Herpes, Syphilis, Gonorrhea, and Human Immunodeficiency Virus Acquired Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure.

Assignment of Insurance Benefits

I authorize East Texas Family Medicine, or its billing representatives to file insurance claims for Medical Services on my behalf and collect for services to which I am entitled. I agree that physician benefits otherwise payable to the Insured are to be made payable to the physician(s) responsible for my care. I authorize and direct my insurance carriers including Medicare, Medicaid, private insurance, or other Health plans to issue payment directly to East Texas Family Medicine

I hereby authorize East Texas Family Medicine and Billing Representatives to: (1) release any information necessary to insurance carriers regarding my illness and treatments, (2) process insurance claims generated in the course of examination or treatment, and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

Precertification of Policy

I understand that this Office Practice/Clinic will assist with insurance pre-certification requirements, but will not assume responsibility for pre-certification or any impact which it may have on insurance payment if we are not given the required information for you in advance of your treatment. Please notify us if you are required to have a referral from your Primary Care Provider.

Financial Responsibility

As consideration for the services provided, I (the patient or responsible party) guarantee payment for any amount due for such services provided by this Office Practice/Clinic. All co-payments and deductibles are due at the time of service.

Certification

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient, or duly authorized by the patient, to accept the terms of this document, and a copy has the same effect as an original.

_____ _____ _____ _____

Patient or Patient's Representative | Relationship | Date Signed | Witness

RELEASE OF PROTECTED HEALTH INFORMATION

Information may be released to the following individual(s)

_____ _____ _____ _____

Name | Relationship | Name | Relationship

Acknowledgement of Review of Notice of Privacy Practices from East Texas Family Medicine

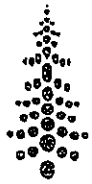
I have read and reviewed East Texas Family Medicine Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient Personal Representative Relation to Patient



East Texas Family Medicine

Dr. James M. Caskey | Dr. Angela C. Hafemick

Due to our new computer system, the following information is nedded

Name: Last:_____ First:_____ MI:____

Date of Birth:_____ Age:_____ Sex: M F SS#_____

Home Address:_____

Phones: home:_____ work:_____ cell:_____

EMAIL Address:_____ or NONE

Pharmacy:_____

Signature:_____ date:_____

936-634-3396 • 936.632.7933 fax • 206 Gene Samford Dr., Suite B • Lufkin, Texas 75904 www.easttexasfamilymedicine.com

East Texas Family Medicine
Dr. James M. Caskey | Dr. Angela C. Hafernick

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePRESCRIBE PROGRAM

ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription(s) from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- **Formulary and benefit transactions-** Gives the healthcare provider information about which drugs are covered by your drug benefit plan.
- **Fill status notification-**Allows health care providers to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up or partially filled.
- **Medication history transaction-** Provides the health care provider with information about your current and pat prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy.

The medication history information would include medications prescribed by your healthcare provider at East Texas Family Medicine as well as other healthcare providers involved in your care and may include sensitive including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance(drug and alcohol) abuse, genetic diseases, and HIV/AIDS. ***As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.***

Consent :

By signing this consent form you are agreeing that your provider at, East Texas Family Medicine may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing, but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to East Texas Family Medicine to enroll me in this ePrescribe Program. I have had the chance to ask questions and all my questions have been answered to my satisfaction.

_____ Print Patient Name _____ Patient Date of Birth

_____ Signature of Patient or Guardian _____ Date

_____ Relationship to patient

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____) _____ **ALT. PHONE** (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name East Texas Family Medicine
Address 206 Gene Samford Dr.
City Lufkin State TX Zip Code 75904
Phone (936) 634-3396 Fax (936) 632-7933

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle _____

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____) _____ **ALT. PHONE** (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

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SIGNATURE X _____ _____
Signature of Minor Individual **DATE**