CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) establishes a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA's privacy rules generally give you the right to request a restriction on uses and disclosures of your protected health information (PHI). You are also provided the right to request confidential communication or to request that a communication of PHI be made by alternative means, such as sending correspondence to your office instead of your home. To better serve you, please complete the following:

PLEASE CONTACT ME IN THE FOLLOWING MANNER:

VERBAL COMMUNICATION:

Home / Cell / Work (circle one)

Please Identify Your Preferred Phone Number: ____________________

☐ Leave message with detailed information.

☐ Leave message with call back number only.

WRITTEN COMMUNICATION:

☐ Mail to this address: ____________________

☐ Fax to this number: ____________________

☐ Affinity Patient Portal *Questions? Please ask the front desk.*

FAMILY MEMBER(S) OR FRIEND(S) WITH WHOM WE MAY DISCUSS YOUR MEDICAL CONDITION:

Name: Address: Phone:

Relationship:

Name: Address: Phone:

Relationship:

Name: Address: Phone:

Relationship:

Name: Address: Phone:

Relationship:

I understand it is my responsibility to provide this office with written changes concerning the release of my PHI.

Patient's Printed Name:

Patient Signature: Date:

NOTICE OF PRIVACY PRACTICES

The attached information describes how information about you may be used and disclosed and how you gain access to this information. Please review it carefully.

UNDERSTANDING YOUR HEALTH RECORD INFORMATION

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit should be made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, medications prescribed, and a plan for future care. This information is often referred to as your health or medical records and serves as a basis for planning your care and treatment. These records foster communications among the healthcare professionals who may contribute to your care both within and outside of **Affinity Health Group, LLC**. These records also provide a means by which you or a third party payer can verify that services billed were actually provided.

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, hereby authorize **Affinity Health Group, LLC** to use my healthcare information for treatment, payment, and healthcare operations.

I understand this consent is voluntary. If I refuse to sign this consent, I understand **Affinity Health Group, LLC** may refuse to treat me.

I understand that I may revoke this consent at any time by notifying **Affinity Health Group, LLC** in writing. If I revoke my consent, such revocation shall not affect any actions that **Affinity Health Group, LLC** may have taken prior to receiving notice of my revocation.

I understand that **Affinity Health Group, LLC** has reserved the right to change its privacy practices and that I may obtain such revised information upon request.

I understand that I have the right to request that **Affinity Health Group, LLC** restrict how my individually identifiable health information is used and disclosed to carry out treatment, payment, and health operations.

I understand that **Affinity Health Group, LLC** is not obligated to agree to such restrictions, but that once such restrictions are agreed to **Affinity Health Group, LLC** shall adhere to such restrictions.

The following notice describes how your medical information may be used and disclosed, and how you can gain access to this information. Please review the information carefully.

Your confidential healthcare information may be released to:

• Other healthcare professionals for the purpose of providing you with quality healthcare.

• Your insurance provider for the purpose of Affinity receiving payment for providing you with needed healthcare services.

• Public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime, or domestic violence.

• Other healthcare providers in the event you need emergency care.

• A public health organization or federal organization in the event of a communicable disease, to report a defective device, an adverse reaction to a biological product (food or medication), or other statutory reporting requirements.

Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.

Your confidential healthcare information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.

You may be contacted by Affinity to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.

You have the right to:

- Restrict the use of your confidential healthcare information. However, Affinity may choose to refuse your restriction if it is in conflict with providing you with quality healthcare, in the event of an emergency situation, or in conflict with state or federal requirements.
- Receive confidential communication about your health status.
- Review and photocopy any/all portions of your healthcare information.
- Make changes to your healthcare information.
- Possess a copy of the Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.

Affinity is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information.

Affinity will abide by the terms of this notice. Affinity does reserve the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information. The latest revision of the Notice of Privacy Practices will be available upon request.

You have the right to file a grievance with Affinity if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please send your complaint to:

Affinity Health Group, LLC
ATTN: Affinity Privacy Officer
130 DeSiard St, Ste 355
Monroe, LA 71201

or call (866) 242-3124

All grievances will be investigated.
For further information about this Privacy Notice, please contact:

Robert Bozeman, General Counsel
(318) 361-0900

This notice is effective as of November 1, 2010.

Printed Name of Patient: ____

Signature of Patient/Representative: ________________________________

Date: ________________

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