MUNSON HEALTHCARE

PHYSICIAN OFFICE AUTHORIZATION FOR TREATMENT AND RELEASE OF MEDICAL INFORMATION

1. CONSENT TO MEDICAL CARE AND TREATMENT

I am being treated at a Munson Healthcare physician office/clinic ("Physician Office"), and I consent to all medical and surgical care, examinations and tests determined by the Physician Office to be necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I assume full risk and responsibility and release the Physician Office and any individual provider from responsibility for things that might go wrong if I do not receive the medical care and treatment recommended to me. I understand that if an employee, physician, or affiliate of Munson Healthcare becomes contaminated with my blood or body fluids through any type of exposure, that I may be tested for the Hepatitis Virus and/or the Human Immunodeficiency Virus (HIV), which causes Acquired Immune Deficiency Syndrome (AIDS).

2. CONSENT TO USE OF INFORMATION

Electronic Health Records: I understand that the Physician Office may collaborate with other health care providers to coordinate, manage, and provide health care to me and I consent to the Physician Office's sharing my health information and records electronically for the purposes of treatment, payment or operations, including improving the overall quality of health care services provided to me (e.g., avoiding unnecessary or duplicate testing, etc.). I consent to the inclusion in the electronic health records of sensitive diagnoses and related information such as HIV/AIDS status, sexually transmitted diseases, genetic information, and mental health and substance abuse, etc. The electronic health records (EHR) will be accessible by Munson Healthcare credentialed physicians/practitioners as well as other individuals approved to access the EHR for purposes related to treatment, payment, health care operations, and/or other purposes permitted by federal and state laws, including the Health Insurance Portability and Accountability Act ("HIPAA"). The Physician Office has implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality and integrity of my medical information as required by HIPAA.

Use and Disclosure of Information: In addition to the above consent to use and share my health information with the Munson Healthcare EHR system, I agree that the Physician Office may use and disclose my health information for a range of purposes including: treatment, eligibility verification, and/or payment to private and public payers or their agents including insurance companies, managed care organizations, my employer (if I am injured at work), state and federal government programs, Workers' Compensation programs, obtaining pre-admission or continued length of stay certification, quality of care assessment and improvement activities, evaluating the performance of qualifications of physicians and health care workers, conducting medical and nursing training and education programs, conducting or arranging for medical review, audit services, ensuring compliance with legal, regulatory and accreditation requirements and public health and health oversight services.

Request for Information from Others: I consent to the Physician Office's request of my health information from other providers of care to me, receipt of and release of my health information, whether written, verbal, or electronic, for the uses described above as well as the Physician Office's participation in the health information exchange described in the Physician Office's Notice of Privacy Practices (NPP). Please refer to the NPP for additional, detailed information regarding the uses and disclosures of protected health information.

3. ASSIGNMENT OF BENEFITS

I hereby assign to and authorize payment of all insurance and health care benefits available to me directly to the Physician Office for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.

4. FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred which are not paid by insurance or health care benefits, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered services also may include those services my physician determines to be medically necessary, but are later determined unnecessary by the payer.

5. PERSONAL VALUABLES. I understand that the Physician Office does not accept responsibility for any lost, stolen or damaged personal items while I am at the Physician Office.

6. SUPPORT PERSON. I understand that the Physician Office allows for a support person during my visit and I will let my provider or the staff know if I would like a support person present.

7. TREATMENT OF MINORS. I, as parent/guardian of a minor receiving treatment, acknowledge that I have been advised to remain on the premises during such treatment, and waive any claim I may have that results from failure to do so.

Patient Name: ______________________________ **Patient Date of Birth:** ____________________

______________________________ ______________________________
Signature of Patient or Patient's Legal Representative **Date & Time**

______________________________ ______________________________
Print Name of Patient's Legal Representative **Relationship of Legal Representative to Patient**
(e.g., parent, guardian, other, please explain)

PATIENT PHONE NUMBER: (Home)______________________ (Day)______________________ (Cell)______________________

EMERGENCY CONTACT: (Name)______________________ (Relationship)__________________ (Phone #)__________________

EMAIL ADDRESS of PATIENT: ____

Does the patient have an Advanced Directive for Medical Care? ☐ NO ☐ YES - please provide our office with a copy.
Does the patient have a Durable Power of Attorney for Healthcare? ☐ NO ☐ YES - please provide our office with a copy.
Does the patient have any special needs? ☐ Hearing Impairment ☐ Wheelchair / Walker Dependent ☐ Vision Impairment ☐ Other:__________

Preferred language for health discussion/information	**Do you consider yourself to be of Hispanic or Latino Origin?**	**Which best describes your race?** (Please answer this question even if you consider yourself Hispanic.)
☐ English ☐ Spanish ☐ Vietnamese ☐ Other (please indicate): ______________________	☐ Yes ☐ No ☐ Declined	☐ American Indian/Alaskan Native Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined-None of the options above apply

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

Under the Health Insurance Portability and Accountability Act (HIPAA) Munson Healthcare will use and disclose (share) your protected health information for 1) Treatment of your medical condition and maintaining the continuity of your care, 2) Payment for medical services provided to you, and 3) Routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law.

I acknowledge: The Notice of Privacy Practices was posted in a clear and prominent location where I was able to view it and if I came in for health care services in an emergency treatment situation, I was able to view the notice as soon as reasonably practicable after the emergency treatment situation.

Permitted Use of Protected Health Information: We may disclose your protected health information to family members or friends who are responsible for or appear to be involved in your medical care or your health care bills. We may also notify your family or friends of your location and condition in the event of an emergency or disaster.

It is our practice to leave messages at the phone number you provide regarding appointment reminders, prescription refills, or referral/testing arrangements. **You may agree to these uses of your protected health information or you may ask us to limit our use of your protected health information.** You agree that Munson Healthcare including our business associates, may contact you by telephone at any telephone number provided by you or associated with your record, including cell phone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using the contact information you provide. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. **Please list the individual(s) we are allowed to share all your protected health information with:**

(Name)______________________________(Relationship)__________________(Phone Number)______________

(Name)______________________________(Relationship)__________________(Phone Number)______________

I agree to all of the above uses and disclosure and understand this will remain in effect until I notify Munson Healthcare of any changes.

______________________________________ ______________________

Print Name of Patient **Patient Date of Birth**

______________________________________ ______________________

Signature of Patient or Patient's Legal Representative **Date & Time**

If an acknowledgement is not obtained, staff must document below the good faith efforts to obtain the acknowledgement and the reason why the acknowledgement was not obtained:

Reason:____

______________________________ ______________________

Signature of Staff **Date & Time**