SOUTHERN CLINIC, P.C.

# HIPAA Patient Disclosure Form for Health Information

Patient Name: _____

Patient Date of Birth: _____ Chart#: _____

The Health Insurance Portability & Accountability Act of 1996 S160.103, also known as HIPAA, defines individual personal health information (PHI) as information, including demographic information collected from an individual and to include information that is:

1. Created or received by a health care provider, health plan, employer or healthcare clearing house.
2. Related to the past, present or future physical, mental health and/or condition of an individual past, present or future payment for provision of health care to an individual.
3. The information, therefore, that identifies an individual or provides a reasonable basis to believe the information can be used to identify the individual.

The PHI can only be disclosed through a permitted disclosure (S164.502) and used by a health care provider in the following manners:

1. For treatment, payment or health care operations as permitted under law.
2. Uses or disclosure to a personal representative assigned by patient.
3. Disclosure to the parents or persons acting in loco to parents to unemancipated minor.
4. For case management, care coordination for the individual, to direct or recommend alternative treatments or therapies, health care providers or health care selling.

I _____am a patient of Southern Clinic, P.C. and understand that I am required to inform the facility of the persons to whom they may disclose my medical information. These assigned persons may be changed at any time by myself. This disclosure becomes effective the date it is signed and will continue until it is cancelled, changed, altered or amended by myself or my appointed legal representative. This facility has notified me that they have a listing of all the persons 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 I UNDERSTAND IT.

_____ _____

Patient Signature Date

I do hereby assign the following persons as trustees of my personal health information and I acknowledge that they may have access my medical information at any time:

Name of Trustee: _____

Relationship: _____

Phone Number: _____

Address: _____

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Name of Trustee: _____

Relationship: _____

Phone Number: _____

Address: _____

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Name of Trustee: _____

Relationship: _____

Phone Number: _____

Address: _____

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Name of Trustee: _____

Relationship: _____

Phone Number: _____

Address: _____

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Name of Trustee: _____

Relationship: _____

Phone Number: _____

Address: _____

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Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____