Orange County Senior Care

Disclosure of Protected Health Information and Notice of Privacy Practices

Name:_____Date of Birth:_____Today's Date:_____

Communication of Information:

Please indicate your preferences for how you would like us to contact you:
Yes ___ or No___ via patient portal (registration required) :email address_____

(_____) _____**Primary Phone Number**
☐ **Do** ☐ **Do Not** leave detailed messages on my primary phone number

(_____) _____**Secondary Phone Number**
☐ **Do** ☐ **Do Not** leave detailed messages on my secondary phone number

Authorization to Share Protected Healthcare information:

Your authorization will allow us to share your medical information with those identified family members, caregivers or others that are involved in your care.

1. Extent of Authorization:
   a. ☐ I authorize the release of my complete health record
   b. ☐ I do not wish to release my health records
   c. ☐ I authorize the release of my records with the **exception** of the following information:
      ☐ Mental health records
      ☐ Communicable diseases (including HIV and AIDS)
      ☐ Alcohol / Drug abuse treatment
      ☐ Other (please specify): _____

Name:_____Date of Birth:_____Today's Date:_____

2. Authorization:

I authorize Orange County Senior Care Medical Group to use and disclose the protected information described below to:

Name: _____Relationship:_____D.O.B:_____All Info: ☐ Restricted Info: ☐

Name: _____Relationship:_____D.O.B:_____All Info: ☐ Restricted Info: ☐

Name: _____Relationship:_____D.O.B:_____All Info: ☐ Restricted Info: ☐

3. Effective Period:
   This authorization for release of information covers the period of healthcare from:

   a. ☐ All past, present, and future periods
   OR
   b. ☐ _____to _____

4. This medical information may be used for 1)Medical Treatment 2)Billing purposes or 3)other purposes I choose by those who have permission.

5. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that if I cancel this authorization it will not be effective 1) for those individuals who have already received information based on the previous authorization, 2) if my authorization was obtained for the purpose of obtaining insurance coverage, the insurer has a legal right to information related to claims.

6. I understand that once the information is disclosed to the authorized person the medical group can no longer protect the information by federal or state law.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be effected by this authorization.

_____

(Signature of patient or personal representative)

_____

(Printed name of patient or person representative and his or her relationship to patient)

_____

(Date)

****

OFFICE USE ONLY:

Entered into NextGen: Date:_____ **Employee Signature:**_____

Patient Consent Agreement

Patient Consent for use and Disclosure
of Protected Health Information

I hereby give my consent for Orange County Senior Care Medical Group to use and disclose protected health information about me to carry out treatment, payment and health care operations. The Notice of Privacy Practices provided by Orange County Senior Care Medical Group describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Orange County Senior Care Medical Group reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Lisa Thurman/Julie Stapf
Orange County Senior Care Medical Group
1101 Bryan Ave
Suite E
Tustin CA, 92780

With this consent, Orange County Senior Care Medical Group may call my home or other alternative location and leave a message or voice mail or in person in reference to any items that assist the practice in carrying out my treatment, payment of health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Orange County Senior Care Medical Group may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment or health care operations, such as appointment reminder cards and patient statements. I have the right to request that Orange County Senior Care Medical Group restrict how it uses or discloses my protected health information to carry out treatment, payment or health care operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Orange County Senior Care Medical Group to use and disclose my protected health information to carry out treatment, payment or health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Orange County Senior Care Medical Group may decline to provide treatment to me.

_____ _____

Signature of Patient (or Parent/Legal Guardian) **Date**

_____ _____

Print Patient's Name Print Parent/Legal Guardian Name
(If Applicable)

ACKNOWLEDGMENT OF RECEIPT OF ORANGE COUNTY SENIOR CARE MEDICAL GROUP NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have been provided a copy of the Notice of Privacy Practices. This notice explains how my personal information can be used and disclosed by this medical office.

Printed Name: _____

Signature: _____ ***Date:*** _____