Additional Use Of Information

Appointment Reminders/Phone Calls:

Your health information and/or demographic information (address, phone number, etc.) may be used by our staff to return calls to the patient and to communicate with the other doctors' offices and/or medical facilities. In addition, your demographic information may be used by our staff to remind you of future appointments or any necessary change that may need to be made regarding your appointment.

Information Of Treatment:

Your health information may be used to send you information on treatment and management of your medical condition that you may find pertinent and interesting. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. They include but are not limited to:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communication concerning your medical condition and treatment
- The right to inspect copies of your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to be informed of any breach of your protected PHI
- The right to receive a printed copy of this notice

When providing information to me, information may be transmitted to me by any or all of the following means (initial all that apply):

_____Telephone messages on an answering machine

_____Email to the following address: _____

North Florida Medical Clinic's Duties

We are required by law to maintain the privacy of your protected of your protected health information and to provide you with this notice of privacy practices. In addition, we also are required to abide by the privacy and practices outlined in this notice.

_____ _____

Signature of Patient Date

North Florida Medical Clinic

PF-100 Notice of Privacy Protection

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to the other healthcare professions for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For examples, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of North Florida Medical Clinic. For example, information on the services you receive may be used to support budgeting and financial reporting, and activities may promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's Public Health Department.

Other Uses and Disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Photograph Consent. I Further consent that photographs may be taken of me or parts of my body by the physician or staff and may be modified or retouched by the physician at his discretion. The photographs shall be used for medical records and, if, in the opinion of my physician, medical research, education or science will benefit from their use, if published in medical journals or medical books I shall not be identified by name and reasonable steps shall be taken to preserve any identity.

_____ _____

Signature of Patient Date

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA RULE 164.508

(You May Refuse to Sign This Authorization)

I, _____, (hereafter "individual") hereby authorize **NORTH FLORIDA MEDICAL CLINIC**, (hereafter collectively referred to as "you") to use and disclose, in form or format, a copy of records concerning Individual, to: _____
(hereinafter "recipients") for the purpose of:
_____
.

I specifically authorize you to use and disclose the following types of super-confidential information (initial where appropriate):
_____ HIV records (including HIV test results) and sexually transmitted diseases
_____ Alcohol and substance abuse diagnosis and treatment records
_____ Psychotherapy records
_____ Tuberculosis
_____ All hospital records
_____ All of the above

I specifically authorize you to use and disclose the following Protected Health Information. Please initial one or more of the following, if applicable:
_____ Written Medical Records
_____ X-rays/MRI/CT
_____ Billing records
_____ Prescription records
_____ Other (specify in detail) _____
_____ All of the above

I understand that my records may be subject to re-disclosure by recipients and unprotected by federal or state law; that this Authorization remains effective until the following date (_____); the following event (_____); or until you actually receive a signed revocation or until the records retention period required under federal and Florida law has expired, whichever first occurs; that I have been given an opportunity to ask questions; that I have received a copy of the signed Authorization; that I may inspect a copy of my protected health information to be disclosed under this Authorization; that you have not conditioned provision of services to or treatment of me upon receipt of this signed Authorization; and that I may refuse to sign this Authorization.

My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided on this form. If the purpose of this Authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this Authorization, you reserve the right to deny treatment associated with such research. If the purpose of this Authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this Authorization, you reserve the right to deny that health care. I understand that I may inspect or copy the information that is used or disclosed. I understand that I may revoke this Authorization at any time by notifying you in writing, except to extent that action has been taken

in reliance on this Authorization; or if this Authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to consent a claim under the policy or the policy itself.

_____

_____

Patient Date