

Electrophysiology Associates, P.C.

Ken L. Curry, M.D. • T. Duncan Sellers, M.D. • Mary R. Olsovsky, M.D.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective 04.01.03

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Federal Government has required that your medical records remain private, confidential, and absolutely not available to anyone without your expressed written consent. Our medical record of your care remains the physical property of *Electrophysiology Associates*. The State of Colorado has supported this law. Patients who are of age less than 18 years, remain under the legal authority of their parents/legal guardians until emancipated.

Health Care Operations

There remains certain instances where, in the process of delivering good medical care to our patients, specific disclosure of information becomes necessary and will be conducted by medical and administrative professionals within this practice, without expressed written permission of each and every specific incident by you. Some examples include but are not limited to:

- A. Calling/faxing your pharmacy medication*
- B. Calling your insurance carrier for billing/reimbursement/preauthorizations*
- C. Notifying your Primary Care Physician (PCP)/referring physician with questions or results of care*
- D. Transcription of letters, consults, test results, progress notes, appointment reminders, etc within the practice to your PCP and any/all consulting physicians*
- E. Handling of the mail; newsletters, claims, bills, referrals etc*
- F. Requesting that the office staff call you to schedule an appointment, acquire a referral, and discuss medications or behaviors preparations prior to or after a medical visit.*
- G. Verbal or written correspondence with Insurance Companies, yours and ours*
- H. Discussing verbal or written complex evaluation and management of your health with peers and/or experts in medical care*
- I. Discussing an opportunity to enroll you in ongoing **Electrophysiology Associates'** Research, and/or continuation in Research studies*
- J. Routine inter-office communication between professional staff of this specialty practice to effectively manage your medical care, and with the administrative staff to coordinate referrals, send appointment reminders, file and store medical records, submit claims and manage accounts billing, co-pays, etc*
- K. Other reasons that may arise to provide you with the most appropriate medical care*

Your Rights Under the Law

1. You have the right to expect that we will respect and honor your personal medical information privacy.
2. You have the right to request a copy of your medical record for yourself and/or sent to another physician.
3. You have the right to discuss any and all information contained in your medical record with your provider of care in a private environment.
4. You have the right to complain to the Office Manager on how your medical information is guarded, handled, and released (or not released) under the tenants of the law.
5. You have the right to express concerns about the law and it's limitations to the U.S. Government Department of Health and Human Services.

- The complete **Notice of Privacy Practices** is available to review in the Waiting Room. A copy of this notice will be made available to you upon request.
- It is our responsibility to guard and maintain information about you and your health in a very private manner. This information will be disclosed within the practice on a “needs to know” basis, and the kept confidential for your assurance that we comply with the Federal, State, and local laws on **“Confidentiality of Medical Information.”**
- Our physicians dictate your Initial Consultation and Follow-Up visits. These are part of your permanent record. If you would like a copy of these reports sent to the address we have on file for you, please initial here: _____.

I consent to allow **Electrophysiology Associates** to use or disclose personal health information about me for the purpose of treatment, payment, and health care operations in accordance with the above described procedures of health information privacy protection. I further understand my rights under the law as also described above.

Patient Signature

Signature of parent/guardian
If patient is a minor

Date