



PATIENT AUTHORIZATION FORM

PATIENT NAME: _____ **DATE OF BIRTH:** _____

I. Authorization To Use, Obtain and Disclose Health Information

I have read and understand Bienville Orthopaedic Specialists, LLC, Notice of Privacy Practices. I authorize Bienville Orthopaedic Specialists, LLC, to use, obtain and disclose specific health and medical information regarding my treatment for the purposes described to/from my insurance company, my primary care physician, area hospitals and facilities and other health care providers. I acknowledge that I am responsible for providing and updating my insurance, demographic, primary care physician as well as other care providers to Bienville Orthopaedic Specialists.

II. Permission To Give Medical Information

I hereby authorize the physicians and staff of Bienville Orthopaedic Specialists, LLC, to give information concerning my health and well being to the person(s) listed below. Including, appointment times, test/lab results, medication, procedures and any information regarding my health

- | | |
|-------------|----------------|
| 1. _____ | _____ |
| (Full Name) | (Relationship) |
| 2. _____ | _____ |
| (Full Name) | (Relationship) |
| 3. _____ | _____ |
| (Full Name) | (Relationship) |

III. Message/Answering Machine

I hereby authorize Bienville Orthopaedic Specialists, LLC, to leave a message on the answering machine/voice mail at :

(Area Code + Phone Number)

IV. Financial

I hereby assign, transfer and set over to Bienville Orthopaedic Specialists all my interest to medical reimbursement benefits under my insurance policy. Furthermore, I attest that I have provided accurate and reliable insurance information to Bienville Orthopaedic Specialists. And, regardless of insurance coverage, I acknowledge that I am financially responsible for all services provided to me by Bienville Orthopaedic Specialists.

Signed: _____ **Date:** _____

(Patient / Parent / Legal Guardian/Representative)



NOTICE OF PRIVACY PRACTICES

This formally mandated form is being provided to you in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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

*If you have any questions about this notice, please contact the Privacy Officer at
Bienville Orthopaedic Specialists, LLC
3635 Bienville Blvd., Ocean Springs, MS 39564
(228) 875-1849*

WHO WILL FOLLOW THIS NOTICE

This notice describes information about privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by healthcare providers you consult with by telephone (when your regular healthcare provider from our office is not available) who provide "call coverage" for your healthcare provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health status, and the healthcare and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We must have your written, signed Consent to use and disclose health information for the following purposes:

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, hospitals, treatment facilities, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering X-rays. Family members and other healthcare providers may be part of your medical care outside this office and may require information we have about you.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan infor-

mation about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Healthcare Operations: We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at the office or if an appointment needs to be rescheduled.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services: We may tell you about health-related products or services that may be of interest or benefit to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred before that time.

If you do revoke your Consent, we will not be permitted to use or disclose information for purposes of treatment, payment, or healthcare operations, and we may therefore choose to discontinue providing you with healthcare treatment and services.

SPECIAL SITUATIONS:

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, national Security and Intelligence: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by the military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal

agencies to monitor the healthcare system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court, administrative order, or liability carrier. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In addition, where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest, in that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide update on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or x-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION:

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent we may have obtained from you. If you give Authorization to use or disclose health information about you, you may revoke that Authorization, in writing at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the Authorization and Consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or healthcare operations, we will have to have both your signed Consent and a special written Authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

You have the following rights regarding health information we maintain about you.

Right to Inspect and Copy: You have the right to inspect a copy of your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend: If you believe health information we have about you is incorrect, you may ask us to amend the

information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, complete and submit a Medical Record Amendment/Correction Form. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.

In addition, we may deny your request if you ask us to amend information that:

- a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- b) Is not part of the health information that we keep.
- c) You should not be permitted to inspect and copy.
- d) Is accurate and complete.
- e) Is relevant to your overall medical history or treatment plan.
- f) Is the physician's opinion.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and healthcare operation. To obtain this list, you must submit your request in writing. It must state a time period, which may not be longer than six years and may not include date before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). We will notify you of our charge for providing the list and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to Agree to Your Request: If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit a written Request For Your Restriction On Use/disclosure Of Medical Information and/or Confidential Communication. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact Bienville Orthopaedic Specialists, LLC at (228) 875-1849, attention Privacy Office.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect. This notice was published and becomes effective on **April 14, 2003**.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the department of health and Human Services. To file a complaint with our office, please contact our Privacy Officer. You will not be penalized for filing a complaint.

If you have any questions about this notice, please contact the Privacy Officer at:



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(228) 875-1849