AUI
ADVANCED UROLOGY INSTITUTE

ADVANCED UROLOGY INSTITUTE
PATIENT INFORMATION FORM

TODAY'S DATE_____

NAME_____ HOME PHONE_____ CELL/OTHER PHONE_____

Primary Address_____ CITY_____ STATE/ZIP_____

Secondary Address_____ CITY_____ STATE/ZIP_____
(If Applicable)

Dates residing at SECONDARY ADDRESS_____ PHONE_____

DATE OF BIRTH_____ SOCIAL SECURITY #_____ MALE_____ FEMALE_____

MARITAL STATUS_____ SPOUSE/NEAREST RELATIVE_____ CONTACT #_____

EMERGENCY CONTACT OTHER THAN SPOUSE/RELATIVE_____ CONTACT #_____

YOUR RACE: Please check one: ☐ AFRICAN AMERICAN ☐ ASIAN ☐ CAUCASIAN ☐ HISPANIC ☐ OTHER_____

YOUR ETHNICITY: Please check one: ☐ HISPANIC /LATINO ☐ NON-HISPANIC/NON LATINO ☐ OTHER_____

YOUR PREFERRED LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ RUSSIAN ☐ OTHER_____

YOUR EMAIL ADDRESS:_____ Preferred Method of Contact:_____

EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART TIME ☐ DISABLED ☐ RETIRED ☐ STUDENT ☐ UNEMPLOYED ☐ OTHER_____

EMPLOYER_____ WORK TELEPHONE NUMBER_____

How do you plan to pay for your medical treatment with us? ☐ Self pay (Cash/Check/Visa/MC) ☐ Medicare ☐ Medicare Supplement
☐ Medicare HMO ☐ Private Insurance (HMO, PPO, Indemnity) ☐ Worker's Compensation

PRIMARY INSURANCE_____ SECONDARY INSURANCE_____

POLICY NUMBER_____ POLICY NUMBER_____

GROUP NUMBER_____ GROUP NUMBER_____

Policyholder Name_____ Policyholder Name_____

Policyholder DOB & SS#_____ Policyholder DOB & SS#_____

Relationship to Policyholder_____ Relationship to Policyholder_____

PLEASE READ AND SIGN:

I HEREBY AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR THE PARTY WHO ACCEPTS ASSIGNMENT. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED. I AGREE TO PAY ALL AMOUNTS NOT PAID BY MY INSURANCE CARRIER ACCORDING TO MY POLICY PROVISIONS AND THE PROVIDER CONTRACT. IN THE EVENT OF A DISPUTED PAYMENT, IT IS MY RESPONSIBILITY TO PAY FOR THE CHARGES AND DISPUTE THE PAYMENT WITH MY INSURANCE CARRIER. IT IS ALSO MY RESPONSIBILITY TO RECEIVE AUTHORIZATION/REFERRALS FOR ANY OFFICE VISIT TO ADVANCED UROLOGY INSTITUTE.

I HEREBY AUTHORIZE MY PHYSICIAN TO ACCESS MY PRESCRIPTION HISTORY IN ORDER TO DETERMINE THE CORRECT FORMULARY IN ACCORDANCE WITH MY HEALTH INSURANCE BENEFITS.

Primary care physician's name and phone number:_____

Pharmacy name and phone number_____

PATIENT/GUARDIAN SIGNATURE_____ HOW DID YOU HEAR ABOUT US?_____

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PATIENT HISTORY FORM

NAME_____ TODAY'S DATE_____ DATE OF BIRTH_____

REFERRED TO OUR PRACTICE BY_____

CHIEF COMPLAINT/ REASON FOR VISIT_____

WHAT PREVIOUS TREATMENT HAVE HOU HAD FOR THIS PROBLEM? By which doctor? _____

_____

HISTORY OF PRESENT ILLNESS: Location of problem: (circle) Abdomen Back Leg Other_____

When did you notice the problem (Circle) 2 days ago 2 weeks ago 1 month ago Other_____

What helps/makes the problem better or worse: (circle) Moving around Standing up Lying on side Other_____

How long does the problem last? (Circle) 30 minutes 1 hour It is always there Other_____

Is the problem constant or variable? (Circle) Dull then sharp Very sharp then leaves Always there Other_____

Does the problem interfere with normal functions? (Circle) Yes No If yes explain_____

UROLOGICAL HISTORY

Do you now have or ever had any of the following?

Kidney stones ( ) NO ( ) YES Comments_____
Frequent urination ( ) NO ( ) YES _____
Trouble starting stream ( ) NO ( ) YES_____
Pain/burning with urination ( ) NO ( ) YES_____
Difficulty holding urine (urgency) ( ) NO ( ) YES_____
Incomplete emptying of bladder ( ) NO ( ) YES_____
Ever had kidney x-rays? ( ) NO ( ) YES_____

Blood in urine ( ) NO ( ) YES Comments_____
Urinate more than 2 x night ( ) NO ( ) YES_____
Decrease size/force of stream ( ) NO ( ) YES_____
Kidney/bladder infection ( ) NO ( ) YES_____
Loss of urine with coughing/sneezing. ( ) NO ( ) YES_____
Gonorrhea/ Syphilis/Herpes ( ) NO ( ) YES _____
Bedwetting as a child? ( ) NO ( ) YES_____

MALES ONLY:
Scrotal Swelling ( ) NO ( ) YES _____
Difficulty with erection ( ) NO ( ) YES
Erections firm for vaginal penetration ( ) NO ( ) YES

Discharge from or sore on penis ( ) NO ( ) YES_____
Are you sexually active? ( ) NO ( ) YES
Do you lose erection during intercourse? ( ) NO ( ) YES

Please complete your most current medication list:

Name of Medication/Over the counter meds/Vitamins/Herbal meds	Strength	# of Times Taken per Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

LIST YOUR PHARMACY NAME AND LOCATION:_____

ALLERGIES TO ANY MEDICATIONS OR FOODS OR IV CONTRAST/X-RAY DYE:_____

_____

PAST MEDICAL HISTORY: (CHECK all that apply to you)

( ) High blood pressure
( ) Diabetes
( ) Heart Attack
( ) Stroke
( ) Atrial fibrillation (irregular heart rate)
( ) Arthritis
( ) Glaucoma
( ) hypothyroid
( ) Kidney stones
( ) Cancer: Type:_____
( ) Enlarged prostate (BPH)
( ) Erectile dysfunction
( ) Kidney failure
( ) High cholesterol
( ) Emphysema (COPD)
( ) Asthma
( ) sleep apnea
( ) Mitral valve prolapse
( ) Blood clot in legs (DVT)
( ) Anemia
( ) chronic back pain
( ) Depression/Anxiety
( ) Neurologic problem

OTHER MEDICAL PROBLEMS NOT LISTED ABOVE _____

_____

PREVIOUS SURGERIES:

( ) Appendectomy
( ) Gall Bladder/Cholecystectomy
( ) Tonsillectomy
( )Heart Surgery
( ) Joint replacement surgery: Type:_____
( ) Pacemaker or AICD defibrillator
( ) Kidney stone surgery: Type:_____
( ) Prostate surgery: Type:_____
( ) Bypass surgery (CABG)
( )Kidney surgery
( ) Hysterectomy
( ) Hernia repair
( ) Bladder surgery: Type:_____
( ) Heart Valve surgery
( ) colon/bowel surgery

OTHER SURGERIES NOT LISTED ABOVE_____

_____

FAMILY HISTORY: Has anyone in your family had? (Circle if yes) Prostate Cancer Kidney Stones Kidney Cancer bladder cancer

Is your mother living? YES NO If NO, year deceased_____ Age at death_____

Is your father living? YES NO If NO, year deceased_____ Age at death_____

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PATIENT HISTORY FORM

SOCIAL HISTORY:

TOBACCO/ ALCOHOL USAGE:

Do you smoke cigarettes? YES NO How many packs per day? _____

If NO, have you ever smoked? YES NO When did you quit? _____

Do you drink alcohol? Never Occasional Daily # Drinks per day_____

ARE YOU : ___MARRIED ___DIVORCED ___SINGLE (NEVER MARRIED) ___WIDOWED

Number of Children?_____

What do you do for work?_____ ( ) Retired ( ) Disabled

REVIEW OF SYSTEMS: Please check Yes or No

General/Constitutional
- Headache ( ) Yes ( ) No
- Chills ( ) Yes ( ) No
- Fever ( ) Yes ( ) No

Opthalmologic
- Blurring of vision ( ) Yes ( ) No
- Double vision ( ) Yes ( ) No
- Eye Pain ( ) Yes ( ) No
- Glaucoma ( ) Yes ( ) No

HEENT/Neck
- Ear Infection ( ) Yes ( ) No
- Sinus Problems ( ) Yes ( ) No
- Sore Throat ( ) Yes ( ) No

Endocrine
- Excessive thirst ( ) Yes ( ) No
- Too hot/too cold ( ) Yes ( ) No
- Fatigue ( ) Yes ( ) No

Respiratory
- Cough ( ) Yes ( ) No
- Shortness of Breath ( ) Yes ( ) No
- Wheezing ( ) Yes ( ) No

Cardiovascular
- Chest Pain ( ) Yes ( ) No
- High Blood Pressure ( ) Yes ( ) No
- Varicose Veins ( ) Yes ( ) No

Gastrointestinal
- Abdominal Pain ( ) Yes ( ) No
- Heartburn/Indigestion ( ) Yes ( ) No
- Nausea/Vomiting ( ) Yes ( ) No

Urologic
- Urinary Retention ( ) Yes ( ) No
- Painful Urination ( ) Yes ( ) No
- Urinary Frequency ( ) Yes ( ) No

Neurologic
- Dizziness ( ) Yes ( ) No
- Numbness/Tingling ( ) Yes ( ) No
- Tremor ( ) Yes ( ) No

Musculoskeletal
- Neck pain ( ) Yes ( ) No
- Back pain ( ) Yes ( ) No
- Joint pain ( ) Yes ( ) No

Dermatologic
- Boils ( ) Yes ( ) No
- Itching ( ) Yes ( ) No
- Rash ( ) Yes ( ) No

Hematology
- Swollen Glands ( ) Yes ( ) No
- Blood Clotting problem ( ) Yes ( ) No

Psychiatric
- Insomnia ( ) Yes ( ) No
- Anxiety ( ) Yes ( ) No
- Depression ( ) Yes ( ) No

COMMENTS: _____

_____

_____

Please fill out if any issues with urinating:

(AUA Symptom Score) In the past month:	Not at all	<1 in 5 times	< ½ times	About ½ the time	> ½ times	Almost always	Your score
How often have you had the sensation of not emptying your bladder?	0	1	2	3	4	5	
How often have you had to urinate less than every 2 hours?	0	1	2	3	4	5	
How often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5	
How often have you found it difficult to postpone urination?	0	1	2	3	4	5	
How often have you had a weak urinary stream	0	1	2	3	4	5	
How often have you had to strain to start urination	0	1	2	3	4	5	
How many times did you typically get up at night to urinate?	0 times	1 time	2 times	3 times	4 times	5 times	
TOTAL SCORE: 1-7 mild; 8-19 moderate; 20-35 severe	///////	///////	///////	///////	///////	//////	

If you were to spend the rest of your life with your current urinary condition just the way it is now, how would you feel about that?

Circle your response: DELIGHTED----PLEASED----MOSTLY SATISFIED----MIXED----MOSTLY DISSATISFIED----UNHAPPY----TERRIBLE

FOR MEN ONLY (SHIM SCORE): **( ) Please check here if you are not sexually active**

CIRCLE the number that best describes your own situation. Select only 1 answer for each question.

Over the past 6 months:	1	2	3	4	5
How do you rate your confidence that you could get and keep an erection?	Very low	low	moderate	high	Very high
When you had erections with sexual stimulation, how often were your erections hard enough for penetration (entering your partner)?	Almost never or never	A few times (<1/2 times)	Sometimes (1/2 times)	Most times (>1/2 times)	Almost always or always
During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Almost never or never	A few times (<1/2 times)	Sometimes (1/2 times)	Most times (>1/2 times)	Almost always or always
During sexual intercourse, how difficult was it to maintain your erection to completion of intercourse	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
When you attempted sexual intercourse, how often was it satisfactory for you?	Almost never or never	A few times (<1/2 times)	Sometimes (1/2 times)	Most times (>1/2 times)	Almost always or always
SCORE (If < 21, speak to your doctor):	//////////	//////////	//////////	//////////	//////////

ADVANCED UROLOGY INSTITUTE
35095 US 19 N, Ste. 202
Palm Harbor, FL 34684

PAUL ARNOLD, MD **YASER BASSEL, MD** **BRIAN HALE, MD**
AMAR RAVAL, MD

MEDICAL RECORDS RELEASE

Name:_____ Maiden Name:_____
Last First MI

Address:_____
Number City State Zip

Social Security #:_____

I authorize_____
(Doctor's Name)

_____
(Address) (City) (State) (Zip)

to furnish protected health information (PHI), including:

_____Office Notes _____Lab/Radiology _____Test Results

to: Advanced Urology Institute OR _____
35095 US 19 N, Ste. 202 _____
Palm Harbor, FL 34684 _____
(727) 771-0600 **FAX (727) 781-9666**

I release and hold harmless_____MD and the providers' medical practice and employees, from all liability, including negligence that may arise from complying with this authorization. I understand that the medical record maintained may contain protected health information (PHI) from other health care professionals. I also understand that Advanced Urology Institute office policy requires prepayment of duplication costs incurred. As authorized by Florida law, fees for copying medical records are: $1.00/page for the first 25 pages, $.25 thereafter. (Chart review _____ pages is $_____)

Signature:_____ Date_____

Witness:_____ Date_____

THIS AUTHORIZATION AND SIGNATURE WILL REMAIN VALID AS LONG AS I AM A PATIENT OF ADVANCED UROLOGY INSTITUTE

AUI
ADVANCED UROLOGY

ADVANCED UROLOGY SPECIALISTS NOTICE OF PRIVACY PRACTICES
As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and modified by the HIPAA Omnibus Final Rule of 2013

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information, also described as "protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. Some of these records may be on paper and some may be in electronic media. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we are in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Advanced Urology Specialist Privacy Officer, 1744 N. Belcher Rd. Clearwater, FL 33765 Telephone: 727-474-3716

C. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS (SUBJECT TO CERTAIN RESTRICTIONS THAT YOU HAVE THE RIGHT TO REQUEST & WE MAY GRANT)

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

Business Associates – Our health care operations may involve the use of other contractors to assist us in billing, collection, record-keeping or other facets of our business operations. Our business associates are required to protect the privacy of your PHI and are not allowed to use or disclose any information other than as specified in our Business Associate contract with them.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled

- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Notifications of Data Breaches.** Our practice may use and disclose your PHI to meet the requirements under the HIPAA rules to notify you and government agencies of any data breach that could potentially result in unintended disclosures of your PHI.

4. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

5. **Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

6. **Marketing of our Services.** Our practice may use and disclose your PHI for purposes of marketing our services to others but only if we have obtained your written authorization to use specified information for this purpose. You have a right to revoke this authorization at any time in writing. Any transaction that occurs prior to such revocation will not be considered an unauthorized disclosure.

7. **Sale of Aggregate Data.** Our practice may sell and disclose your PHI to other covered entities but only if we have obtained your written authorization prior to doing so. You have a right to revoke this authorization at any time in writing. Any transaction that occurs prior to such revocation will not be considered an unauthorized disclosure.

8. **Serious Threats to Health or Safety.** Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military.** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National Security.** Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. **Inmates.** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers' Compensation.** Our practice may release your PHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR PHI: You have the following rights regarding the PHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **AUI Privacy Officer 727-474-3716** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request with certain exceptions (see below).** If we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **AUI Privacy Officer 727-474-3716** . Your request must describe in a clear and concise fashion:

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(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

You have a right to revoke such restrictions in writing to the same representative of our practice.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. This includes your right to an electronic copy of any electronic medical records that we maintain. You may request this electronic copy be transmitted to you or to any other individual or entity that you designate. We will make reasonable efforts to transmit this electronic copy in the format you request. However, if the PHI is not readily producible in this format, we will provider your record in our standard electronic format or in hard copy. You must submit your request in writing to **AUI Privacy Officer 727-474-3716** in order to inspect and/or obtain a copy of your PHI. We have 30 days to comply with your request. Our practice may charge a reasonable fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **AUI Privacy Officer 727-474-3716.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI, outside of those for treatment, payment or health care operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **AUI Privacy Officer 727-474-3716.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to Notice of Data Breach. In accordance with specifications of the U. S. Department of Health and Human Services, you have the right to be notified by us of a data breach that unintentionally discloses any or all of unsecured electronic PHI to an unauthorized party.

7. Right to Restrict Disclosures of Services Paid "Out of Pocket". You have a right to forego a filing of insurance claims and restriction of disclosures to your health plan for any specific service that you pay for out of pocket. This request will be honored by us as long as the full payment is received at the time of service.

8. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **AUI Privacy Officer 727-474-3716**

9. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **AUI Privacy Officer 727-474-3716.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

10. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **AUI Privacy Officer 727-474-3716.**

PRINT NAME_____ **Signature**_____ **DATE**_____

May we leave a message on your answering machine? Yes_____ **No**_____

Names of family members and telephone numbers we may contact_____

_____

_____

_____

BayCare
Health System

Electronic Medical Records

Details About Your Health Information in BayCare eHX and the Consent Process:

1. **How Your Health Information Will Be Used:** Your health information will be used by members of the BayCare eHX only:
   - To provide you with medical treatment and related services
   - To check whether you have health insurance and what it covers
   - To evaluate and improve the quality of medical care provided to all patients
   - For administrative management of the BayCare eHX
2. **What Types of Health Information About You Are Included:** If you give consent, members of the BayCare eHX may access ALL of your health information available through the BayCare eHX. This includes information created before and after the date of this Consent Form. Your health information available through the BayCare eHX will include all of your demographic, insurance and medical information. For example, your health information may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. As part of this Consent Form, you specifically consent to the release of health information that may relate to sensitive health conditions, including but not limited to:
   - Substance abuse
   - HIV/AIDS
   - Psychiatric/mental health conditions
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - Sexually transmitted diseases
3. **Where Health Information About You Comes From:** Health information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid/Medicare program and other health organizations that exchange health information electronically.
4. **Who May Access Information About You, If You Give Consent:** Access to the BayCare eHX will be limited to only those members of the BayCare eHX who have agreed to use the BayCare eHX consistent with your permission as set forth in this Consent Form and who have agreed to the overall terms and conditions established for use and operation of the BayCare eHX.
5. **Improper Access to, or Use of, Your Information:** If at any time you suspect that someone who should not have seen or received access to your health information has done so, please contact the BayCare Privacy Department at (727) 820-8024.
6. **Re-disclosure of Information:** Any electronic health information about you may be re-disclosed by members of the BayCare eHX to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. You understand that the protected health information disclosed pursuant to this Consent Form may not be protected by federal law once it is disclosed by your physician.
7. **Effective Period:** This Consent Form will remain in effect until the day you withdraw your consent.
8. **Withdrawing Your Consent:** You can withdraw your consent at any time by giving written notice to Chris Eakes, Manager of eHX, BayCare Health System, 17757 U.S. Highway 19 N., Suite 500, Clearwater, FL 33764. Organizations that access your health information through the BayCare eHX while your consent is in effect may copy or include your health information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove your health information from their records.
9. **Copy of Form:** You are entitled to get a signed copy of this Consent Form after you sign it.

BayCare Health System

Electronic Medical Records

Consent to Share My Health Information With the BayCare Electronic Health Exchange

The BayCare Electronic Health Exchange (BayCare eHX) is an exciting program designed to improve your health care and make office visits easier and more convenient. This authorization will allow all of your doctors participating in the BayCare eHX to enroll you in the BayCare eHX and to disclose your demographic, insurance and medical information (collectively, your **"health information"**) to the BayCare eHX so that it can be shared with other providers of health care, including doctors, nurses, health professionals, hospitals and other health care facilities. Only health care providers and authorized personnel that participate in the BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate the operation of the BayCare eHX, will be able to access your health information. The BayCare eHX will allow your providers access to your health information more quickly and accurately than with paper charts.

You may use this Consent Form to decide whether or not to allow the BayCare eHX to see and obtain access to your health information in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on the BayCare eHX for your medical treatment.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, members of the BayCare eHX may see and get access to all of my health information through the BayCare eHX."

If you check the **"I DENY CONSENT"** box below, you are saying "No, members of the BayCare eHX may not be given access to my health information through the BayCare eHX for any purpose."

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices: You can fill out this form now or in the future. You have two choices:

☐ **YES, I GIVE CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

☐ **NO, I DENY CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

_____ _____ _____

Printed Name of Patient/Representative Signature of Patient/Representative Date

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: _____

_____

_____

Relationship to Patient: _____