HEMOPHILIA
— OUTREACH CENTER —

HIPAA AUTHORIZATION - For Use or Disclosure of Protected Health Information

As the patient, I understand that I am the primary person to receive information from physicians and other caregivers regarding my health condition, treatment, and progress. However, other individuals may desire or have a need to receive information about my condition and health care services. I authorize the staff & physicians at Hemophilia Outreach Center (identified as "HOC") to provide verbal information about my **TREATMENT** (Appointments, Medications, Referrals, Lab and other diagnostic results and medical information) and **BILLING** (information about my account to assist me with my insurance and payments) to the persons named below for the purpose of keeping them informed of my progress or assisting with my care. (Please note, we reserve the right to utilize clinical judgement in determining with whom we need to communicate based upon your health care needs, i.e., emergency.)

Patient Name: _____ Date of Birth: _____
Address: _____City: _____ State: _____ Zip: _____
Telephone Number: _____Type (circle): Home Mobile Work

I hereby authorize HOC to verbally disclose protected health information to the following: (I agree that this authorization includes the release or disclosure of information listed above in **Treatment** and **Billing**:

Name	Relationship	Telephone Number
Name	Relationship	Telephone Number
Name	Relationship	Telephone Number

☐ I decline HOC verbally sharing my treatment information with others, excluding emergency situations as indicated above.

I **DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED** (as defined by applicable state and federal laws):
☐ Alcohol/Drug Abuse ☐ Mental Health/Developmental Disabilities ☐ STD's ☐ HIV test results
☐ AIDS/AIDS related treatment

☐ I authorize HOC staff to work on my behalf and utilize my information to initiate or maintain my participation in manufacturer related co-pay patient assistance programs.

☐ Voice Mail: Except for appointment reminders and billing inquiries, I understand that I will not be left voicemail messages regarding my health unless I agree to the following. I understand that messages left on voice mail may be subject to access by others and therefore are not a secure way to communicate confidential information. I understand that because of this risk HOC advises that protected health information should **not** be left on voice mail. **By checking this box, I agree that HOC may communicate my health information noted above to me via my voice mail at the number listed above** and I release HOC and its employees, officers, and directors form all liability for any unintended disclosure or consequence because of communicating my protected health information to me in this manner.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may possibly be re-disclosed by the recipient and/or no longer be protected by Federal privacy standards.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: Right to Information Disclosed – I understand that I have a right to know what information was disclosed to the above individuals. **Right to Receive a Copy of This Authorization** – I understand this authorization is voluntary, that if I agree to sign this authorization, I will be provided with a copy of it upon my request. **Right to Refuse to Sign This Authorization** – I understand that I am under no obligation to sign this form. Treatment, payment, enrollment, or eligibility for benefits may not be based upon my decision to sign this authorization. **Right to Revoke This Authorization** – I understand that I may revoke this authorization. A description of how to revoke the Authorization and any exceptions are included in the Notice of Privacy Practices.

No Conditions
I understand that Hemophilia Outreach Center may not condition my treatment or services based on the provision that I authorize this disclosure of my protected health information.

Effect of Granting this Authorization
I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

EXPIRATION: I understand that this authorization will remain in effect until _____ **or** I choose to revoke it.
(Indicate event or date)

_____ _____
Signature of Patient or Legal Representative Date

_____
Printed Name

If signed by a person other than the patient, complete the following:

1) Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased.
2) Legal authority: ☐ a parent* ☐ legal guardian ☐ activated POA for Health Care
   ☐ next of kin/executor of deceased

*By signing above, I hereby declare that I have not been denied physical placement of this child.