SMH Physicians Network

SMH Slidell Memorial Hospital

Your Hospital for Life.

Consent for Use of Patient Information

This consent is for disclosure of protected health information for purpose of treatment, operations or payment.

I understand that *SMH Physicians Network* may need to obtain, use and disclose information about my health or medical problems for the purposes of providing, arranging, conducting, or referring me for, diagnosis and treatment, for obtaining payment for the services rendered to me and for the operations of the practice. I consent to the release, use and disclosure of my information for the purposes of treatment, payment, and health care options.

I understand that my consent is not needed if the law requires *SMH Physicians Network* to report some aspect of my protected health information to a government agency.

Examples would include suspected abuse, communicable disease and potential for serious bodily harm to myself or others.

I understand that I have the right to review *SMH Physicians Network* privacy notice, to request restrictions on the use of my information and to revoke my consent at a later date.

I understand that if I withhold consent for the use of my information for the purposes of treatments, payment or operations, *SMH Physicians Network* may decline to undertake my care.

Patients Name: _____ Relationship: _____

Patient/Parent/Guardian Signature:_____ Date: _____

Privacy Notice

Consent for Use of Patient Information Explanation

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

Once you sign SMH Physicians Network's consent form for Use of Patient Information, we may use and disclose medical information about you in order to carry out your treatment, to obtain payment for services rendered to you and to carry out the operations of the practice. Examples of how we may use and disclose information about you for providing treatment, obtaining payment and operating are:

Examples of uses and disclosure for treatment:

If a nurse practitioner, physician or physician assistant at the practice refers you for cardiac stress test and needs to call the cardiologist for results, the clinician may give your name and reason for ordering the stress test to the cardiologist's office.

A nurse practitioner, physician or physician assistant at the practice may call you from time to time to advise you of new alternatives to your treatments.

Examples of uses and disclosures to obtain payment:

The practice's billing office may submit a claim form, containing your name, address, social security number, diagnosis and the procedure performed in our office to your insurance company.

Examples of uses and discloses to carry out operations of the practice:

The practice's nurse practitioners, physicians and physician assistants may audit (read and comment upon) your chart in order to track and improve our performance in assuring the screening test and immunizations are done on time. The practice's staff may mail you reminders of upcoming appointments.

We may leave messages at the telephone numbers you provide, asking you to return our call.

The practice may use or disclose protected health information about you for other purposes, without consent, if we are required by law to disclose to governmental authorities. Such uses or disclosure may include:

- Suspect abuse of a child
- Documented communicable disease
- Fraudulently abusing narcotic prescriptions

The practice will make other uses and disclosures of protected health information only with your written authorization. You may revoke such authorizations. You have rights regarding your protected health information. You may:

- Request restrictions on certain uses and disclosures of protected health information, but we are not required to agree to request restriction
- Request that your protected health information is not sent to your health plan for payment purposes if you are paying for services fully out of pocket. (HITECH effective date 2/17/10)
- Request that you receive confidential communication of protected health information
- Request to inspect and copy your own protected health information
- Request that your health information be amended
- Request an accounting of disclosures of protected health information made by the practice in the past 3 years (HITECH effective date 1/1/11)
- Request a paper copy of this notice.

The practice is required to act on your request within 48 hours. The practice is required by law to maintain the privacy of protected health information and provide individuals with notice of its legal duties and privacy practices with respect to protected health information. The practice is required to abide by the terms of this notice and to provide individuals with revisions to the notice. If private information is breached you will receive a written notification of the incident (HITECH effective date 2/1/2010).

You may complain to the practice or the Secretary of Health and Human Services if you believe that your privacy rights have been violated. File a complaint with the practice by writing:

SMH Physicians Network
1001 Gause Blvd, Box 75
Slidell, LA 70458

No one will attempt to retaliate against you for filing a complaint.
For more information about this notice, contact:

I have reviewed this notice and believe I understand my rights to privacy.

Signature: _____

Printed Name: _____