TAMPA BAY HEARING & BALANCE Center
A division of Select Physicians Alliance

Loren J Bartels MD FACS Christopher J Danner MD FACS Kyle P Allen MD MPH

5 Tampa General Circle Suite 610 / Harbourside Medical Tower / Tampa, FL 33606
P: (813) 844 4900 F: (813) 844 4905 http://www.tampabayhearing.com

RECORDS REVIEW SERVICE PACKET

Welcome to Tampa Bay Hearing and Balance Center a division of Select Physicians Alliance. Loren J Bartels MD FACS, Christopher J Danner MD FACS, and Kyle P Allen MD MPH are specialists in Otology, Neurotology and Skull Base Surgery and we look forward to providing a high quality records review.

NEXT STEP: IMPORTANT RECORDS REVIEW CHECKLIST

Our office phone is (813) 844-4900 if you have questions. Please ask to speak with a "records review specialist".

Use the following as a checklist to prepare for the records review service. Once we receive your deposit and medical records we will contact you with an estimated cost of service.

- Please print and complete this complete packet.
- Complete and sign the Financial Agreement Form acknowledging that this service is not a covered benefit by your insurance.
- Complete the included Services Request and Health History Information form.
- Complete and sign the last page after reviewing the packet.
- Make a check payable to "Select Physicians Alliance" with memo line "Records Review Service Deposit" for $75. We can also take a credit card over the phone. This $75 is not refundable.
- Obtain a copy of your MRI/CT Scan of the Brain/Ear on CD or Film. CD is preferred, especially if you wish to review images over video conference or email exchange.
- Gather and prepare a copy of your medical records including diagnostic testing and your MRI/CT Scan. Example records may include:
  - Previous physician notes
  - Diagnostic testing such as:
    - Hearing tests
    - Balance tests
  - Lab testing and blood work that pertain to your chief complaint.
  - Diagnostic imaging such as:
    - MRI of the brain / IACS (internal auditory canals)
    - CT Scan of the head / temporal bones / skull base / mastoids
- Send your payment to the address below or provide a credit card over the phone.

  Tampa Bay Hearing & Balance Center
  ATTN: Records Review Service
  5 Tampa General Circle STE 610
  Tampa, FL 33606-3659
- Send the prepared documents from above to one of the following:
  - **Email: recordsreview@tampabayhearing.com**
  - **Fax: 813.844.4905**
  - **Mail: same as address above**

  Patient Name: _____ **Date of Birth: _____** *(r r s)*

Financial Agreement

Notifier: Select Physicians Alliance dba Tampa Bay Hearing & Balance Center

Patient Name: _____ Patient Date of Birth: _____

Responsible Party Name: _____ Responsible Party Date of Birth: _____

Summary: Records Review Service is a Cash Only Service, not covered by private or public Insurance, including Medicare and Medicaid.

Note: Insurance, including Medicare and Medicaid does not pay for everything, even some care that you or your health care provider have good reason to think you need. Insurance, including Medicare and Medicaid, does not pay for the **records review service** below, and you are responsible for payment.

Service	**Reason Insurance / Medicare / Medicaid Will Not Pay:**	**Estimated Cost**
Records Review Service	This service is being provided for patients who have an extensive number of records, defined as 5 reports or more and that want to receive a preliminary synopsis of their case prior to an in office appointment. Insurance does not cover records review or telemedicine services. **NOTE ALTERNATIVE OFFICE VISIT CHOICE:** We do offer traditional, insurance based, office visit appointments. If you chose that option, we need to consider the best use of the allotted time for that appointment. We ask that you prioritize your complaint and pick the 4 most pertinent records to review for that initial appointment. Time will be spent to address the most important issue and subsequent appointments will address additional concerns and records.	There is a non-refundable $75 processing fee to be sent in with the records review packet. This fee will be applied to the total if you agree to the service and estimate. An estimate will be provided prior to service rendered and if agreed on, payment is due prior to rendering service. The rate is $125 per 30 minute block. If additional time is required / desired beyond the estimate, the remainder will be billed to patient.

Acknowledgement: By signing below you understand that private and public insurance, including Medicare and Medicaid, will not be billed, by us or by you, for the **records review service** and that you are responsible for the cost of this service. If you do not want this service, we have provided an alternative choice above. This service requires a non-refundable $75 processing fee which is due with the records review packet that you send in to start the process. We will provide you an estimate for the service, and if agreeable to you, the estimate is due prior to services rendered. If additional time is required / desired, the remainder will be billed to patient / responsible party.

Signature of Responsible Party:	**Date:**

Services Request and Patient Health History Information

NOTE: You may have completed this specific page online. If you have, you may skip this single page and continue to the next page that starts with "Chief Complaint".

SERVICES REQUEST

Please indicate, by circling, the service(s) you would like to utilize for your Records Review appointment. How would you like to receive information from the physician?

- Secure Email Exchange
- Teleconference
- Videoconference

PATIENT HEALTH HISTORY INFORMATION

Patient Demographics:		**Guarantor (Responsible Party):**	
First Name:		First Name:	
Middle Initial:		Middle Initial:	
Last Name:		Last Name:	
Suffix:		Suffix:	
Date of Birth:		Date of Birth:	
Gender:		Gender:	
Social Security:		Social Security:	
Marital Status:		Marital Status:	
Street Address:		Street Address:	
City:		City:	
State:		State:	
Zip:		Zip:	
Email Address:		Email Address:	
Cell Phone:		Cell Phone:	
Work Phone:		Work Phone:	
Home Phone:		Home Phone:	
Language:			
Race:			
Ethnicity:			
Guardian Name:			
Emergency Contact:			
Emergency Phone:			
Occupation:			
Employer Name:			
Employer Phone:			

Physician References:	
Primary Care Physician:	
Referring Physician:	
Neurologist:	
Cardiologist:	
Audiologist:	
How did you hear about us?	**Internet Friend Physician News Paper Family Member**

NOTE: We are not collecting insurance information with this records review packet. This service is not covered by public or private insurance including Medicare and Medicaid. Call us and ask us whether we take your particular health insurance for traditional insurance based in office appointments.

Chief Complaint:

Circle the most important word below plus circle R=Right L=Left or B=Both. The purpose of the main complaint is to identify what is the most bothersome to you.

Hearing Loss : R/L/B Ear Noise : R/L/B Ear Pain : R/L/B Ear Tumor : R/L/B Dizziness/Imbalance

History of Present Illness:

These questions are designed to help you prepare for your appointment. Read the questions through first; then write a concise answer next to each question below. We will clarify and get more detail during your visit with us.

- **When** did the main problem you circled above start?
- Does the beginning of the main problem have a **context** such as a cold, stress, noise exposure, other?
- Circle whether the main problem is **PRESENT IN EPISODES** or **CONSTANTLY PRESENT**.
- Approximately **how long** does the main problem last when it is present?
- **Where** is the main problem located? (RIGHT, LEFT, BOTH)
- What makes the main problem **worse**?
- What makes the main problem **better**?
- How would you describe the **nature** of the main problem? Use a descriptive word or set of words such as muffled, spinning, tin like, bell ringing, lightheaded, etc.

- What **other symptoms happen at the same time** as the main problem you circled above? This could be any of the other words you didn't circle in the main complaint area as well as other symptoms.

- How **severe or intrusive** is the problem we are trying to address?
- Have you taken any medication, typically for a significant hospitalization; that is known to be **toxic** to the ears? Name the medication:
- Do you have a history of **viral infection** such as any of the various herpes viruses (examples: fever blisters, shingles, chicken pox, other)? Name the virus(es):

CONTINUED ON NEXT PAGE

Past Medical History: (circle and write approximate date to the right of each historical item):

Condition	Date	Condition	Date
Urinary Incontinence		Anemia	
Kidney Stones		Fainting/Syncope	
Chronic Renal Failure		Heart attack/problems	
Dialysis Treatments		High cholesterol	
Bladder problem		High blood pressure	
Kidney problem		Low blood pressure	
Sexual Function problem		Abnormal heart beat	
Asthma		Cancer _____ (type): Chemo or Radiation?	
Pneumonia		Arthritis	
Sinusitis		TMJ/Jaw Pain	
Sleep apnea		Migraine	
Memory loss		Sinus headache	
Speech disturbance		Tension headache	
Stroke		Back pain	
Seizures		Neck pain	
Incoordination		Poor vision in one eye	
B12 Deficiency		Cataracts	
Multiple sclerosis		Macular degeneration	
Low sugar		Double vision	
Diabetes Type 1		Distorted vision	
Diabetes Type 2		Glaucoma	
Thyroid disorder		Ocular migraine	
Depression		Measles	
Unusual Stress		Chicken pox	
Anxiety		Shingles	
Treatment by psychiatrist		Fever Blisters	
Reflux/hiatal hernia		Herpes	
Colitis		Hepatitis	
Crohn's disease		Meningitis	
Diverticulitis		Tuberculosis	
Diverticulosis		Lupus	
Liver failure		HIV or AIDS	

Review of Systems: (circle all current symptoms that apply, **if no symptom exists for the section please circle "*NONE*"**)

CONSTITUTIONAL			
	NONE	Fever	Change in weight
	Night sweats/chills	Fatigue	
SKIN			
	NONE	Healing Problems	Rash
	Discolorations		
EYES			
	NONE	Glaucoma	Visual Disturbance
	Dry Eyes	Double Vision	
Review of Systems continued next page…			

EARS, NOSE, THROAT			
	NONE	Epistaxis	Change in voice
	Ringing in the ears	Allergies	Snoring
	Ear pain or itch	Throat pain	Sinus problems
	Ear drainage	Hearing loss	
CARDIOLOGY			
	NONE	Chest pain	Irregular heart rhythm
	Murmur	Leg swelling	
ENDOCRINOLOGY			
	NONE	Sleep problems	Temperature intolerance
	Excessive thirst		
GASTROENTEROLOGY			
	NONE	Loss of appetite	Nausea or vomiting
	Heartburn	Change in bowel habits	Difficulty swallowing
HEMATOLOGY/LYMPH			
	NONE	Easy bruising	Bleeding/bruising disorder
	Blood clot in legs	Blood transfusions	
MUSCULOSKELETAL			
	NONE	Joint stiffness	Arthritis
	Osteoporosis treatment	Pain in jaw with chewing	Muscle weakness
	Bone pain	Leg cramps	Joint pain
	Joint Swelling	Back pain	Neck pain
	Muscle aches		
RESPIRATORY			
	NONE	Asthma	Shortness of breath
	Cough	Blood in sputum	
NEUROLOGY			
	NONE	Headache	Paralysis/weakness
	Tingling numbness	Dizziness	Memory loss

Allergies:

Medication	**Allergic Reaction**

Current Medications:

Medication	**Start Date**	**Dosage**	**How Often**	**Time of Day**	**Reason for Taking**

CONTINUED ON NEXT PAGE

Surgical History: (circle and write approximate date underneath each surgery)

Ear (RIGHT, LEFT, BOTH) Appendix Tonsils & Adenoids C-Section Breast

Cataracts Prostate Sinus Hysterectomy Stomach Stents

Heart bypass Carotid arteries Other: _____

Hospitalization: (for issue other than surgeries listed above, write date and reason for hospitalization)

Family History: (circle and write family relation underneath word)

Balance Problems Vertigo Ménière's disease Convulsions/Seizures

Hearing loss Otosclerosis (hardened ear bones) Migraines

Social History: (write in or circle answer)

Occupation:	_____			
Caffeine:	None	Occasional	Moderate	Frequent
Smoking:	Never Smoker	Current Daily	Current Sometimes	Former Smoker
	Light Smoker	Heavy Smoker	Other tobacco use	
Alcohol:	Rare	Occasional	Moderate	Heavy
Stress:	Mile	Moderate	High	
Exercise:	Some	Occasional	Moderate	Frequent
Scuba Diving History:	No	Yes		
Frequent Air Travel:	No	Yes		
Diet:	Regular	Vegan	Vegetarian	

CONTINUE WITH SIGNATURE FORMS ON NEXT PAGE

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Revised as of July 31, 2013

By law, we are required to make available to you a copy of our Notice of Privacy Practices ("Notice"). By signing below you acknowledge that you received, or been offered and declined, a copy the Notice.

A current copy of the Notice is also posted in the office, or is available to you upon request. If the Notice is revised, you may review and obtain the new version at any time.

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 or wish to receive additional information about the matters covered by this Notice of Privacy Practices ("Notice"), please contact the Privacy Officer, for Select Physicians Alliance ("SPA") Sheryl A. Watts, COO, at 1149 Nikki View Dr., Brandon, FL 33511or call: (813) 571-7184.

This Notice is provided to you in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and associated regulations, as may be amended (collectively referred to as "HIPAA") describing SPA's legal duties and privacy practices with respect to your Protected Health Information ("PHI"). SPA is required to abide by the terms of this Notice currently in effect, and may need to revise the Notice from time to time. Any required revisions of this Notice will be effective for all PHI that SPA maintains. A current copy of the Notice will be posted in each office and you may request a paper, or electronic, copy of it.

PHI consists of all individually identifiable information which is created or received by SPA and which relates to your past, present or future physical or mental health condition, the provision of health care to you, or the past, present or future payment for health care provided to you.

USE AND DISCLOSURE OF PHI FOR WHICH YOUR CONSENT OR AUTHORIZATION IS NOT REQUIRED

HIPAA permits SPA to use or disclose your PHI in certain circumstances, which are described below, without your authorization. However, Florida law may not permit the same disclosures. SPA will comply with whichever law is stricter.

1. **Treatment**: SPA may use and disclose your PHI to provide, coordinate or manage your health care and related services, including consulting with other health care providers about your health care or referring you to another health care provider for treatment. For example, SPA may discuss your health information with a specialist to whom you have been referred to ensure that the specialist has the necessary information he or she needs to diagnose and/or treat you. Further, SPA may contact you to remind you of a scheduled appointment.

2. **Payment**: SPA may use and disclose your PHI, as needed, to obtain payment for the health care it provides to you. For example, SPA may disclose to a third-party payer the treatment you are going to receive to ensure that the payer will cover that treatment. Additionally, SPA may disclose to a third party payer or grant funding service, as necessary, the type of services you received to reimbursement for your treatment.

3. **Health Care Operations**: SPA may use or disclose your PHI in order to carry out its administrative functions. These activities include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualification of health care professionals, conducting training programs in which students provide treatment under the supervision of one of SPA's health care professionals, business planning and development, business management and general administrative activities. For example, SPA may disclose your PHI to accreditation agencies reviewing the types of services provided.

4. **Required by Law**: SPA may use or disclose your PHI to the extent that such use or disclosure is required by law.

5. **Public Health**: SPA may disclose your PHI to a public health authority, employer or appropriate governmental authority authorized to receive such information for the purpose of: (a) preventing or controlling disease, injury or disability; reporting disease or injury; conducting public health surveillance, public health investigations and public health interventions; or at the direction of a public health authority, to an official of a foreign government agency in collaboration with a public health authority; or reporting child abuse or neglect; (b) activities related to the quality, safety or effectiveness or activities or products regulated by the Food and Drug Administration; (c) notifying a person who may have been exposed to a communicable disease or may otherwise be at risk of spreading a disease or condition.

6. **Abuse, Neglect or Domestic Violence**: SPA may disclose your PHI to a government authority authorized to receive reports of abuse, neglect or domestic violence if it reasonably believes that you are a victim of abuse, neglect or domestic violence. Any such disclosure will be made: 1) to the extent it is required by law; 2) to the extent that the disclosure is authorized by statute or regulation and SPA believes the disclosure is necessary to prevent serious harm to you or other potential victims; or 3) if you agree to the disclosure.

7. **Health Oversight Activities**: SPA may disclose your PHI to a health oversight agency for any oversight activities authorized by law, including audits; investigations; inspections; licensure or disciplinary actions; civil, criminal or administrative actions or proceedings; or other activities necessary for the oversight of the health care system, government benefit programs, compliance with government regulatory program standards or applicable laws.

8. **Judicial and Administrative Proceedings**: SPA may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process upon receipt of "satisfactory assurance" that you have received notice of the request.

9. **Law Enforcement Purposes**: SPA may disclose limited PHI about you for law enforcement purposes to a law enforcement official: (a) in compliance with a court order, a court-ordered warrant, a subpoena or summons issued by a judicial officer or an administrative request; (b) in response to a request for information for the purposes of identifying or locating a suspect, fugitive, material witness or missing person; (c) in response to a request about an individual that is suspected to be a victim of a crime, if, under limited circumstances, SPA is not able to obtain your consent; (d) if the information relates to a death SPA believes may have resulted from criminal conduct; (e) if the information constitutes evidence of criminal conduct that occurred on the premises of SPA ; or (f) in certain emergency circumstances, to alert law enforcement of the commission and nature of a crime, the location and victims of the crime and the identity, or description and location of the perpetrator of the crime.

10. **Coroners, Medical Examiners and Funeral Directors**: SPA may disclose your PHI to a coroner or medical examiner for the purpose of identification, determining a cause of death or other duties authorized by law. SPA may disclose your PHI to a funeral director, consistent with all applicable laws, in order to allow the funeral director to carry out his or her duties.

11. **Research**: SPA may use or disclose your PHI for research purposes, provided than an institutional review board authorized by law or a privacy board waives the authorization requirement and provided that the researcher makes certain representations regarding the use and protection of the PHI.

12. **Serious Threat to Health or Safet**y: SPA may disclose your PHI, in a manner which is consistent with applicable laws and ethical standards, if the disclosure is necessary to prevent or lessen a serious threat to health or safety of a person or the public, or the information is necessary to apprehend an individual.

13. **Specialized Government Functions**: SPA may also disclose your PHI, (a) If you are a member of the United States or foreign Armed Forces, for activities that are deemed necessary by appropriate military command authorities to assure the proper execution of a military mission; (b) to authorized federal officials for the conduct of lawful intelligence, counter-intelligence and other national security activities authorized by law; (c) to authorized federal officials for the provision of protective services to the President, foreign heads of state, or other people authorized by law and to conduct investigations authorized by law; or (d) to a correctional institution or a law enforcement official having lawful custody of you under certain circumstances.

14. **Workers' Compensation**: SPA may disclose your PHI as authorized by, and in compliance with, laws relating to workers' compensation and other similar programs established by law.

USES AND DISCLOSURES TO WHICH YOU MAY OBJECT

15. If you do not object to the following uses or disclosures of your PHI, SPA may: 1) disclose to a family member, other relative, a close personal friend, or other person identified by you the information relevant to their involvement in your care or payment related to your care; 2) notify others, or assist in the notification, of your location, general condition, or death; or 3) disclose your PHI to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES OF PHI

16. Any use or disclosure of your PHI that is not listed herein will be made only with your written authorization. You have the right to revoke such authorization at any time, provided that the revocation is in writing, except to the extent that: 1) SPA has taken action in reliance on the prior authorization; or 2) If the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

YOUR RIGHTS REGARDING YOUR PHI

17. **Restriction of Use and Disclosure**: You have the right to request that SPA restrict the PHI it uses and discloses in carrying out treatment, payment and health care operations. You also have the right to request that SPA restrict the PHI it discloses to a family member, other relative or any other person identified by you, which is relevant to such person's involvement in your treatment or payment for your treatment. By law, SPA is not obligated to agree to any restriction that you request. If SPA agrees to a restriction, however, it may only disclose your PHI in accordance with that restriction, unless the information is needed to provide emergency health care to you. If you wish to request a restriction on the use and disclosure of your PHI, please send a written request to the Privacy Officer which specifically sets forth: 1) that you are requesting a restriction on the use or the disclosure of your PHI; 2) what PHI you wish to restrict; and 3) to whom you wish the restrictions to apply (e.g., your spouse). SPA will not ask why you are requesting the restriction. The Privacy Officer will review your request and notify you whether or not SPA will agree to your requested restriction. You also have the right to request to restrict disclosure of your PHI to a health plan, if the disclosure is for payment or health care operations and the disclosure pertains to a health care item or service for which you have paid out of pocket in full.

18. **Marketing and Sale of PHI**: Most uses and disclosures of PHI for marketing and the sale of PHI require your authorization.

19. **Fundraising**: SPA may contact you for purposes of fundraising to support its programs. You have the option to opt-out of this type of communication.

20. **Confidential Communications**: You have the right to receive confidential communications of your PHI. You may request that you receive communications of your PHI from SPA in alternative means or at alternative locations. SPA will accommodate all reasonable requests, but certain conditions may be imposed.

To request that SPA make communications of your PHI by alternative means or at alternative locations, please send a written request to the Privacy Officer setting forth the alternative means by which you wish to receive communications or the alternative location at which you with to receive such communications. SPA will not ask why you are making such a request.

21. **Access to PHI**: You have the right to inspect and obtain a copy of your PHI maintained by SPA. Under HIPAA, you do not have the right to inspect or copy information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding, or information that SPA is otherwise prohibited by law from disclosing.

If you wish to inspect or obtain a copy of your PHI, please send a written request to the Privacy Officer. If you request a copy of your PHI, SPA may charge a fee for the cost of copying and mailing the information. You may also request that a copy of your PHI be transmitted to you electronically.

HIPAA permits SPA to deny your request to inspect or obtain a copy of your PHI for certain limited reasons. If access is denied, you may be entitled to a review of that denial. If you receive an access denial and want a review, please contact the Privacy Officer. The Privacy Officer will designate a licensed health care professional to review your request. This reviewing health care professional will not have participated in the original decision to deny your request. SPA will comply with the decision of the reviewing health care professional.

22. **Amending PHI**: You have the right to request that SPA amend your PHI. To request that an amendment be made to your PHI, please send a written request to the Privacy Officer. Your written request must provide a reason that supports the request amendment. SPA may deny your request if it does not contain a reason that supports the requested amendment. Additionally, SPA may deny your request to have your PHI amended if it determines that: 1) the information was not created by SPA and amendment may be made elsewhere; 2) the information is not part of a medical or billing record; 3) the information is not available for your inspection; or 4) the information is accurate and complete.

23. **Notification of Breach**: SPA will notify you following a breach of your PHI as required by law.

24. **Accounting of Disclosure of Your PHI**: You have the right to request a listing of certain disclosure of your PHI made by SPA during the period of up to six (6) years prior to the date on which you make your request. Any accounting you request will not include: 1) disclosures made to carry out treatment, payment or health care operations; 2) disclosures made to you; 3) disclosures made pursuant to an authorization given by you; 4) disclosures made to other people involved in your care or

made for notification purposes; 5) disclosures made for national security or intelligence purposes; 6) disclosure made to correctional institutions or law enforcement officials; or 7) disclosures made prior to April 14, 2003. The right to receive an accounting is subject to certain other exceptions, restrictions and limitations set forth in applicable statutes and regulations.

To request an accounting of the disclosures of your PHI, please send a written request to the Privacy Officer. Your written request must set forth the period for which you wish to receive an accounting. SPA will provide one free accounting during each twelve (12) month period. If you request additional accountings during the same twelve (12) month period, you may be charged for all costs incurred in preparing and providing that accounting. SPA will inform you of the fee for each accounting in advance and will allow you to modify or withdraw your request in order to reduce or avoid the fee.

25. **Obtaining a Copy of this Notice**: You have the right to request and receive a paper or electronic copy of this Notice at any time.

COMPLAINTS

26.If you believe that your privacy rights have been violated, you may file a complaint with SPA or with the Secretary of Health and Human Services. To file a complaint with SPA, please contact the Privacy Officer at the address listed on page 1 of this notice. All complaints must be submitted in writing. SPA WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT. *Select Physicians Alliance, P.L. 1149 Nikki View Dr., Brandon, FL 33511*

Authorization of Release Confidential Prescription Information

I hereby authorize all pharmacies and insurers as may have access to my medication history for the past two years as may exist in a privacy respecting database to release information to Tampa Bay Hearing & Balance Center.

Optimizing our ability to care for you and lowering your risk of adverse reaction to medications and other treatment is the goal of obtaining your medication information. This consent grants permission to health care providers, pharmacists and the active staff of the above named prescription data management services to release a list of all medications for which these entities have medication records which may be of a personal and private nature. Note that these databases may be incomplete if your pharmacy does not participate in database sharing. Neither will this list include over-the-counter medications and supplements/vitamins which you use. This list will not contain information on how well you utilized the prescriptions or why you may have stopped the prescription. To the degree you have supplied allergy information, this database should provide an allergy list but if you have developed an allergy which you have not told a participating pharmacy service about, it will not be listed. Thus, we still need you to bring us a list of all medications and supplements which you use and a complete list of your allergies, including the type of allergic reaction you experienced to the degree that you can give that information to us. Please sign below indicating that all prescription information is to be released.

The patient or legal representative may revoke this consent at any time by written notice to the Tampa Bay Hearing and Balance Center. Revoking this release-of-information consent will not have any effect on any information already used or disclosed before the written notice is received.

This authorization form expires when the above specified information has been transmitted/received, or not later than a year from the date of signature. The patient or legal representative may inspect and/or request a copy of all medical records but a copying charge may be assessed.

The patient or legal representative may refuse to sign or to allow the above specified information to be released or transmitted with recognition that lack of information can affect diagnosis and treatment. The physician will not refuse to care for a patient without this information unless it is viewed by the physician to be critical information in which case the physician may suggest an alternative provider.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT OR PAYMENT

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, and treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.
- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.
- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on your answering machine, your mobile voice mail or with a household family member.
    - o [ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member.
    - o [ ] Please check here if you do not want us to leave a message on your mobile voice mail.
- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.
- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information_____
  _____
- You may request a copy of, or as a new patient, will be given a copy of our "*Notice of Patient Privacy Practices"* that provides a more complete description of health information uses and disclosures as required by the HIPAA standard.
- You have read or have had the right to read the "*Notice of Patient Privacy Practices"* prior to signing this authorization.

Signature Page

The undersigned has read and agrees to the information stated above for the:

- Notice of privacy Practices for Protected Health Information
- Authorization of Release Confidential Prescription Information
- Authorization for the Use or Disclosure of Health Information for Treatment or Payment

Patient Name (Print): _____

Legal Representative (Print): _____

Signature of Patient or Legal Representative: _____

Date: _____

If Legal Representative, list Relationship to patient: _____