AMORY SURGERY CLINIC

HOAT M. HOANG, M.D., FACS KIRK A. CADDELL, M.D., M.S.
1127 EARL FRYE BOULEVARD, SUITE B, AMORY, MS 38821
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HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirement of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), U.S.C. Section 1320d, et, seq., and regulations promulgated there under, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

By signing this authorization, you acknowledge and agree that **Amory Surgery Clinic** may use and/or disclose a copy of the specific health and medical information for the patient listed below to Hoat M. Hoang, M.D., or Kirk A. Caddell, M.D., 1127 Earl Frye Boulevard, Suite B, Amory, MS 38821 for the following purposes: Treatment, Payment and Healthcare Operations.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand **Amory Surgery Clinic's HIPAA** Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures under HIPAA. While **Amory Surgery Clinic** has reserved the right to change the terms of its Privacy Notice, copies of the privacy notice as amended are available from **Amory Surgery Clinic** by sending a written request with the return address to 1127 Earl Frye Boulevard, Suite B, Amory, MS 38821 or P. O. Box 329, Amory, MS 38821. In accordance with your rights under, and subject to certain restrictions imposed by HIPAA, you may inspect or copy your PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the event that **Amory Surgery Clinic** has taken action on reliance on it. A revocation is effective upon receipt by **Amory Surgery Clinic** of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of (a) revocation of authorization, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purpose for which this authorization was originally obtained, to be determined in the reasonable discretion of **Amory Surgery Clinic**, or (d) six (6) years from the date this authorization was executed.

By signing this authorization, you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA. **Amory Surgery Clinic** will provide the patient listed below with a copy of this signed authorization.

Acknowledge and agreed to by:

_____

Print Patient Name

_____ _____

Signature of Patient/ Personal Representative **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I certify that I have received a copy of **Amory Surgery Clinic's** Notice of Privacy Practices. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills, or in the performance of **Amory Surgery Clinic's** healthcare operations. The Notice of Privacy Practice also describes my right and **Amory Surgery Clinic's** duties with respect to my protected health information. The Notice of Privacy Practices is posted in the waiting room and a copy was given to me personally.

Amory Surgery Clinic reserves the right to change the privacy practices that are described in the Notice of Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient/ Personal Representative **Date**

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize release of any medical information necessary to process this claim. I request payment to myself or to the party who accepts assignment. I authorize payment of medical benefits to undersigned physicians for services rendered. Also, if applicable, I authorize payment of Medigap benefits to be made to undersigned physician for services rendered.

_____ _____

Signature of Patient/ Personal Representative **Date**

Please list anyone other than yourself that you would allow to have information about you.

_____ _____

_____ _____