USMD | UANT
A USMD AFFILIATE

HIPAA Disclosure

I understand that, under the Health Insurance Portability & Accountability Act of 1996, as amended and supplemented (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). PHI may originate in your medical record at UANT, an affiliate of USMD Affiliated Services, or may be received from outside health entities and filed in your medical record.

I understand that this information can and will be used by UANT, an affiliate of USMD Affiliated Services, to: (a) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly, (b) Obtain payment from third-party payers, (c) Conduct normal healthcare operations such as quality assessments and physician certifications, (d) Notification of educational events specific to my medical condition through UANT, an affiliate of USMD Affiliated Services, or networking organizations, (e) Consent to property transfer of specimen (tissue obtained during a medical test) to UANT, an affiliate of USMD Affiliated Services, and (f) Any such other purposes permitted under HIPAA.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that UANT, an affiliate of USMD Affiliated Services, has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices from my local office or by contacting the Privacy Officer at 6333 Nth. State Highway 161, Suite 200, Irving, TX 75038.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Designation of Those Who Can Receive Information About My Care

To allow a family member, other relative, or a close personal friend to have access to PHI.

I designate the following individuals to have access to information about me that is created by or on behalf of UANT, an affiliate of USMD Affiliated Services, and that this information can include PHI. I understand that I may revoke this designation at any time by completing a new form; and that this designation will not expire unless and until I actively revoke it. I understand that these individuals will not be able to request a paper or electronic copy of my health records without my having completed an Authorization to Release Medical Information form.

I understand that my healthcare treatment or payment, or my enrollment or eligibility for benefits cannot be conditioned on my designating or not designating an individual below.

I understand that this designation does NOT allow for the release of any information concerning drug abuse, alcohol abuse, psychological or psychiatric conditions, HIV/AIDS testing or status, abortion, or sexually transmitted disease, if any.

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

I prefer to be contacted in the following manner:

Primary Phone#: (   ) ______________________

- ☐ Leave message with contact number only.
- ☐ Leave message with detailed information.
- ☐ Do not leave message.

Secondary Phone#: (   ) ______________________

- ☐ Leave message with contact number only
- ☐ Leave message with detailed information.
- ☐ Do not leave message.

I prefer to receive reminders regarding upcoming appointments in the following manner:

☐ Leave message. ☐ Decline/Do Not Call.

I prefer to receive a summary of my office visit in the following manner:

☐ Printed. ☐ Decline. ☐ "Follow My Health" Patient Portal (sign up required for access).

______________________ Signature of Patient or Personal Representative

______________________ Patient Date of Birth

______________________ Date

______________________ Print Name of Patient or Personal Representative

______________________ Relationship to Patient