LevMed

Patient Name:	Date of Birth

Instructions: The following section to be completed by office. Last section to be completed by Patient or Guardian.

Release Information From	Release Information To
❑ LevMed, 1519 Dr. Martin Luther King Jr., St. N., St. Petersburg, FL 33704 Phone: (727) 314-6472 Fax: (727) 619-2310 ❑ Other (*Specify facility/individual & address below, including phone/fax if known*) _____ _____ _____ _____	❑ LevMed, 1519 Dr. Martin Luther King Jr., St. N., St. Petersburg, FL 33704 Phone: (727) 314-6472 Fax: (727) 619-2310 ❑ Other (*Specify facility/individual & address below, including phone/fax if known*) _____ _____ _____ _____

Purpose of Release

❑ Treatment/Continued care	❑ Legal purposes	❑ Other
❑ Application for insurance	❑ Payment of Insurance Claims	_____
❑ Personal		_____
❑ Disability determination		_____

Information To Be Released

(Required: Check all that apply)

❑ Clinic notes	❑ Pathology reports
❑ History and physical	❑ Radiology reports
❑ Hospital notes	❑ Radiology images
❑ Hospital discharge summary	❑ Billing information
❑ EKG's	❑ Other (*specify information to be released below*)
❑ Immunization records	_____
❑ Laboratory reports	_____
❑ Operative reports	_____
	_____
	_____
	_____

Service dates (optional)
From To Information needed by (optional)

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law**. Information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal law.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing**, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  - ❑ Legal Guardian or Conservator ❑ Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:
  - ❑ Parent ❑ Legal Guardian

Signature (*Required*)	**Date Signed** (*Required*) (Month, DD, YYYY)
Printed Name of Person Signing (if not patient)	
Mailing Address of Patient - Street	

City	State	Zip Code	Phone

NOTICE OF PRIVACY PRACTICES

Patient:_____ DOB: _____

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations. We may also create and distribute de-identified health information by removing all references to individually identifiable information

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Medical Records Requests

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received the Notice of Privacy Practices.

Patient (Print):_____ Date: _____

Patient Signature: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations

_____ I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Patient:_____ **DOB:** _____

RIGHT TO SHARE INFORMATION WITH FAMILY AND FRIENDS

LevMed reserves the right to communicate PHI with family or friends when it is deemed to be in the best interest of the patient as described in the Notice of Privacy.

In order to have your PHI shared in other circumstances with members of your family or friends, please list those individuals who LevMed is authorized to release information to.

_____

_____

_____

_____

_____

_____ _____
Signature of Patient Date

ALTERNATIVE COMMUNICATION RELEASE FORM

I authorize LevMed, in regards to my protected health information (PHI): (➔ *all that apply*)

____To call me at work
____To call me at home
____To call my cell phone
____To send me a message via text messaging
____To contact me via video telephone interface (telemedicine)
____To speak with anyone listed on the Right To Share Information list
____To only speak with me
____To fax information to me at this secured number _____
____Other

LevMed

Authorization to Release Protected Information
Notification of Controlled Substances

While LevMed is able to prescribe necessary scheduled medications, it is important to disclose our philosophy regarding some of the stronger—and potentially harmful— pain relief medication. LevMed is aware of the potential side effects of this class of medication (particularly benzodiazepines and opiates), and will do our best to curb their use or find less potentially harmful pharmacological options. Please do not join LevMed with the assumption that Dr. Levine will fill controlled substances on the initial visit. If certain chronic pain narcotics are necessary, LevMed will refer out to a local pain management specialist. Candidly, if you are expecting LevMed to prescribe high dose narcotics such as opiates, LevMed may not be the right practice for you.

Sincerely,

Dr. Brett Levine

_____ _____

Patient Signature Date

LevMed

Patient:_____ DOB: _____

Patient No-Show Policy and Procedure

LevMed provides standards for scheduling patient appointments that help enhance patient care. Please understand that our appointment times are scheduled to allow us to take care of each patient's individual needs during the patients visit. Top promote efficient access to our office, we require that any appointment that is no longer needed or unable to be kept must be cancelled more than 24 hours in advance.

In an event an appointment is missed or cancelled with less than 24 hours' notice or no notice, LevMed follows the process below.

- **1st missed appointment**: We will call you and reschedule the appointment
- **2nd missed appointment**: We will call and offer to reschedule. You will receive an email explaining our policy, and you may be charged a missed appointment fee of up to $35.
- **3rd missed appointment**: This could result in discharge from our practice. You may be asked to find another physician outside of LevMed.

Our main concern is to manage your health care with the highest quality skill and efficiency we can offer. If you have question, our staff will be happy to answer them.

_____ _____

Signature of Patient Date