BLANCA GONZALEZ, M.D.

PATIENT INFORMATION

Name: _____ **DOB:** _____

Sex: M / F **Age:** _____ **Race:** _____ **SSN:** _____

Primary Language: _____ **Marital Status:** _____

Next of Kin: _____ **Phone:** _____

Address: _____ **City:** _____

State: _____ **Zip:**_____ **Phone:** _____ **Cell:** _____

Emergency Contact: _____ **Relation:** _____ **Phone:** _____

Reason for visit: _____

_____

_____

Primary Insurance: _____ **ID#:** _____

Secondary Insurance or (RX Ins.): _____ **ID#:** _____

Medication Allergies: _____

Other Allergies: _____

Any Disabilities: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____

DOB: _____ **Last four digits of SSN:** _____

I here provide authorization to release my confidential medical records to:

BLANCA N. GONZALEZ, MD

1435 W 49th Place, Suite 701

Hialeah, FL 33012

Phone: (786) 218-7863

Fax: 1 (866) 557-6953

☐ **All records**

☐ **Partial records:** _____

Patient's Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

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 CAREFULLT

The Health Insurance Portability & Accountability Act of 1966 (HIPPA) is a federal program that requires that all medical record and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept 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 misused personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of health information and how we ay 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 operations.

- Treatment means providing, coordinating or maintaining health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment.

We also create and distribute de-identified reminders or 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 Privacy Officer:

- The rights 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 aide 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.

This notice is effective as of **October 2019** and we are required to abide by the terms of 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 provisions effective for all protected health information that we maintain. We will post and you may request a written copy of privacy Practice from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & human service, Offices 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.

Please contact us for more information: **BLANCA N. GONZALEZ, M.D.**

1435 W 49 PL, SUITE 701

Hialeah, FL 33012

(786) 218-7863

For more about HIPPA or to file a complaint: **The U.S. department of Health & Human Services**

Office of Civil Rights

200 Independence Ave, SW

Washington, D.C. 20201

(202) 619-0257

Patient's Signature: _____ Date: _____

PATIENT CONSENT FORM

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Practice Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information ma be disclosed or used for treatment, payment or health care operations.
- The Practice has a notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will the cease.
- The practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____

Relationship to Practice (if other than patient): _____

Signature: _____ **Date:** _____

Witness Name: _____

Practice Representative's Signature: _____ **Date:** _____

SIGNATURE ON FILE AGREEMENT

I request that payment of authorized benefits be made on my behalf to Blanca N. Gonzalez, MD for services rendered by this provider. I authorize any holder of medical information about me to release the health care financing and its agents, or to my insurance company or the billing agent of this supplier, any information required to process this or a related claim. I give permission to use a copy of this authorization in place of the original, send request payment for medical insurance benefits paid to the Party that accepts assignments.

Patient Signature: _____ **Date:** _____