University Health Center
7797 N. University Drive, Suite 101
Tamarac, Florida 33321
Phone: 954-722-6050
Fax: 954-720-7776

HIPAA FORM

In order to expedite your check-in process, please print the "New Patient" and "HIPAA" forms. Complete these forms prior to your appointment and give them to our receptionist at the time of check-in.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Medical Record #: _____

Date of Admission: _____ /_____ /_____
(day) (month) (year)

My signature on this form acknowledges that I have received a copy of University Health Center's "Notice of Privacy Practices". I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by University Health Center and of my rights with respect to my health information.

I have been provided the opportunity to discuss concerns I may have regarding the privacy of my health information.

_____ Date: _____ /_____ /_____
Patient Signature *(day) (month) (year)*

_____ Date: _____ /_____ /_____
Signature of Patient's Representative *(day) (month) (year)*
(if patient is unable to sign)

TO BE COMPLETED BY ADMITTING CLINICIAN IF FORM IS NOT SIGNED

1. Was the patient provided with a copy of the office's "Notice of Privacy Practices"?

   ☐ Yes ☐ No *(check one)*

2. Briefly describe efforts made to obtain the patient's acknowledgement of receipt of the "Notice" and explain why the patient was not able or willing to sign this form:

_____

_____

_____ Date: _____ /_____ /_____
Signature of Admitting Clinician *(day) (month) (year)*

We are HIPPA compliant! Your information WILL be protected.

PATIENT AUTHORIZATION RELEASE FORM

Patient Name: _____ DOB: _____ /_____ /_____
(day) (month) (year)

Street Address: _____

City: _____ State: _____ Zip: _____

Cell Number: ( ) _____ - _____

Home Number: ( ) _____ - _____

Work Number: ( ) _____ - _____ Ext: _____

E-mail: _____

I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) described below who I am authorizing to use and/or disclose my health information may not condition treatment, payment, enrollment in health plan or eligibility in health care benefits on my decision to sign this authorization. **University Health Center may condition the provision of research-related treatment on the provision of an authorization to use and/or disclose an individual's health information for such research. If you wish to make such a condition, you must include a description of these circumstances.**

1. **I authorize the following health information to be use and/or disclosed:**

   _____

   _____

2. **I authorize the person/organizations to use and/or use my health information:**
   University Health Center and any physician, medical center, practitioner, agency or media (print/broadcast/film, etc.) that we may use for the sole purpose of advertising or marketing the procedure that we are requesting from you.

3. **I authorize the person/organizations to receive and/or use my health information:**
   University Health Center and any physician, medical center, practitioner, agency or media (print/broadcast/film, etc.) that we may use for the sole purpose of advertising or marketing the procedure that we are requesting from you.

4. **I authorize my health information to be use and/or disclosed for the following purpose(s):**

   _____

   _____

5. **My right to revoke this authorization:** I understand that I have the right to revoke this authorization at any time. I also understand that my revocation of this authorization must be in writing and sent to Dr. Steven Cane; 7797 N. University Drive, Tamarac, Florida 33321. I am aware that my revocation will not be effective if (i) this authorization was obtained as a condition for obtaining insurance and applicable law permits the insurer to contest the claim or the policy itself or (ii) to the extent the person(s) and/or organization(s) identified above have already acted in reliance upon this authorization.

PATIENT AUTHORIZATION RELEASE FORM

(continued)

6. **Redisclosure of health information:** I understand that if the person(s) and/or organization(s) listed above are not healthcare providers, health plans or health care clearinghouses that are subject to the federal privacy standards, the health information disclosure pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and/or organization(s) may redisclose my health information without obtaining my authorization.
7. **Disclosure of direct or indirect remuneration received by any person and/or organization authorized to use and/or disclose my health information:** I understand that NO ONE outside University Health Center will be receiving direct or indirect remuneration in connection with the use and/or disclosure of my health information.
8. **Expiration of authorization:** This authorization will effective indefinitely.

_____ Date: _____ /_____ /_____

Patient Signature

If the patient is unable to sign, complete the following:

Patient is unable to sign because: _____

Name of personal representative (e.g., health care power of attorney, guardian, other statutory authorization)

Street Address: _____

City: _____ State: _____ Zip: _____

Home Number: ( ) _____ - _____

Work Number: ( ) _____ - _____ Ext: _____

_____ Date: _____ /_____ /_____

Signature of personal representative

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: _____ DOB: _____ /_____ /_____
(day) (month) (year)

Street Address: _____

City: _____ State: _____ Zip: _____

Home Number: ( ) _____ - _____ Email: _____

Medical Record #: _____ SSN#: _____ - _____ - _____

I, _____, am requesting that University Health Center communicate with me in the alternative manner and/or location described below regarding my health information. I understand that University Health Center may deny this request if it imposes an unreasonable administrative burden.

Description of the health information that must be communicated confidentially: The following is a description of the specific health information to which this request applies:

_____

_____

Alternative manner and/or location: I request that University Health Center only communicate with me in the following manner and/or at the location described below:

_____

_____

By signing this form, I am confirming that it accurately reflects my wishes.

_____ Date: _____ /_____ /_____
Signature of patient *(day) (month) (year)*

If signed by personal representative:
Name of personal representative: _____

Relationship to participant or nature of authority: _____

_____ Date: _____ /_____ /_____
Signature of personal representative *(day) (month) (year)*

Submit Form to: Dr. Steven Cane – University Health Center

REQUEST FOR RESTRICTIONS ON USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____ /_____ /_____
(day) (month) (year)

Street Address: _____

City: _____ State: _____ Zip: _____

Home Number: ( ) _____ - _____ Email: _____

Medical Record #: _____ SSN#: _____ - _____ - _____

I, _____, am requesting that University Health Center's use and/or disclosure of my health information in the manner described below. I understand University Health Center may deny this request. I also understand that if agreed to, University Health Center may not be able to honor this request if I require emergency treatment.

Description of restriction of the health information to be used or disclosed: The following is a description of the specific health information I wish to restrict:

_____

_____

Persons/organizations restricted from use and/or disclosure of health information: I request that the following person(s) and/or organization(s), not be allowed to use and/or disclose the health information described below:

_____

_____

_____

By signing this form, I am confirming that it accurately reflects my wishes.

_____ Date: _____ /_____ /_____
Signature of patient *(day) (month) (year)*

If signed by personal representative:
Name of personal representative: _____

Relationship to patient: _____

_____ Date: _____ /_____ /_____
Signature of personal representative *(day) (month) (year)*