



13838 US Hwy 441/27 Lady Lake, FL 32159 Phone (352) 753-1612	1950 Laurel Manor, Bldg. 240 The Villages, FL 32159 Phone (352) 753-1612	8110 CR 44 Leg A Leesburg, FL 34788 Phone (352) 323-8868	1840 Classique Ln Tavares, FL 32778 Phone (352) 323-8868	255 Citrus Tower Blvd, Suite 208A Clermont, FL 34711 Phone (352)-404-4334
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HIPAA Information and Consent Form Acct # _____

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a “friendly” version. A more complete text is available in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination rooms, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes in office policy and new technology that you might find valuable or informative, insurance items, and items pertaining to your clinical care such as: laboratory and pathology results, diagnostic results, among others.
3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance duties.
4. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
5. We agree to provide patient with access to their medical records in accordance with state and federal laws.
6. We may change, add, delete, or modify any of these provisions to better serve the needs of both the patient and the practice.
7. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
8. I authorize the following people to be able receive information regarding my medical condition:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

SIGN: _____

DATE: _____



Gastroenterology:

Lily Tran, M.D.
 Rafael Fleites, M.D.
 Garth George, M.D.
 Ivelisse Lopez, M.D.

General Surgery:

MaoHao (Charlie) Han, M.D.

Proctology:

Robert Gillon, D.O.

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To (Physician or Facility) : _____

Address: _____

Phone: _____ Fax: _____

Patient Name: _____

SSN: _____ DOB: _____

I, _____, request that any and all records specified below be released to Advanced Gastroenterology & Surgery Associates.

Primary Care Physician or Specialist Office

- Lab Reports within past 6 months – 12 months
- Office note – Last visit
- Operative/ Pathology Reports – Colonoscopy, EGD within past 12 years
- CT Scans/X-Rays/MRI/ US of abdominal area within 12 months
- Hospital records within past 12 months

Hospital

- Hospital records within past 12 months

Imaging/ Radiology Facility

- CT Scans/X-Rays/MRI/ US of abdominal area within 12 months

PLEASE BE ADVISED THAT THIS IS TO BE CONSIDERED A FULL AND COMPLETE AUTHORIZATION TO RELEASE ALL MEDICAL RECORDS BY ABOVE MENTIONED FACILITY.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION AND THAT THE PROVIDER/FACILITY/INSURANCE COMPANY LISTED ABOVE AS THE RELEASING AGENCY IS RELEASED FROM ALL LEGAL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THE INFORMATION REQUESTED.

I FUTHER UNDERSTAND THAT I AM AUTHORIZING THE RELEASE OF INFORMATION FROM THE RECORDS WHOSE CONFIDENTIALITY AND PRIVILEGED STATUS IS PROTECTED FROM FEDERAL REGULATIONS AND FLORIDA STATUTE AND THAT A RE-DISCLOSURE OF THIS INFORMATION BY THE RECEIVING AGENCY IS PROHIBITED WITHOUT WRITTEN EXPRESS PERMISSION FROM THE PATIENT.

Signature of Patient or Empowered Representative: _____

Signature of Witness: _____ **Date:** _____

***** Valid for 90 days *****

Confidentiality Notice:

This message is intended only for the use of the individual or entity to which it is addressed. It may contain legal information that is privileged, confidential or medically privileged and exempt from disclosure under applicable law. If the receiver of this message is not the intended recipient, you are hereby notified that any distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and return this original message to us at the above address via the United States Postal Service. Revised-JA 10/2011