Retro Health Disease Management Program Consents

Acknowledgement and Authorization Form

Please initial each line and sign

Patient Name: _____ Date of Birth: _____ Phone: _____

- I have read and understand the HIPAA/Privacy Policy for Retro Health, LLC. Policy is attached. **Initials** _____
- I hereby consent Retro Health, LLC to perform reasonable and necessary medical examinations and appropriate testing. **Initials** _____
- I hereby assign my insurance benefits to be paid directly to the healthcare provider at Retro Health, LLC. **Initials** _____
- I authorize Retro Health, LLC to release medical information required to process my claim. **Initials** _____
- I authorize Retro Health, LLC to obtain/have access to my medication history. **Initials** _____
- I authorize my healthcare team at Retro Health, LLC to contact me by calls, text messages and emails. **Initials** _____

I certify that I have read and fully understand the above statements. I understand that this consent is valid and remains in effect until I withdraw my consent in writing.

Signed_____ **Date:** _____

Consent for Verbal Communication

I authorize Retro Health, LLC physicians and staff to discuss my personal medical health information, in person and/or by telephone, with the following family members and/or friends involved in my medical care for the following purposes:

- To schedule or confirm my appointments;
- To discuss prescriptions either new or refills;
- To discuss results of diagnostic tests, diagnosis, prognosis, and treatment plans; or
- To leave a voicemail with the above information.

I understand that this document applies to healthcare providers and/or employees with Retro Health, LLC. I understand that this authorization is voluntary and that once this information is disclosed to the person(s) designated that it may be redisclosed by them and may no longer be protected by state or federal privacy laws.

Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Understand no *PHI (Patient Health Information) will be discussed with any not listed above.

- ○ I do not authorize Retro Health, LLC to discuss my personal medical health information with any family members and/or friends that are involved in my medical care.

Signed_____ **Date:** _____

Authorization for Release of Protected Health Information

Retro Health, LLC

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Facility/Doctor Name: _____

Address: _____ City, ST, Zip: _____

Phone Number: _____ Fax: _____

Facility/Doctor Name: _____

Address: _____ City, ST, Zip: _____

Phone Number: _____ Fax: _____

Facility/Doctor Name: _____

Address: _____ City, ST, Zip: _____

Phone Number: _____ Fax: _____

I, Patient Name: _____ Date of Birth: _____,
authorize you to disclose the Protected Health Information described below to:

Retro Health, LLC
1001 S. Mays St. Suite 205, Round Rock, TX 78664
Phone: (844) 573-3733 Fax: (833) 483-1565
Email: Virtualinfo@RetroHealth.com

The complete history records in your possession concerning my illness and treatment for **Continuation of Care**:

_____ All Health Information	_____ Consultation Reports	_____ Pathology/Lab
_____ History & Physical	_____ EKG/Cardiology Reports	_____ Discharge Summary
_____ Progress Notes	_____ Diagnostic Test Reports	_____ Radiology Reports & Images
_____ Past/Present Medications	_____ Patient Allergies	_____ Operations Reports

Please release the information for the following dates/time-period: _____

Date Records Needed By: _____ Please Mail, Fax, or Email (All Secure)

My initials below indicate special permission to release any information other than indicated above:

_____ Drug, Alcohol, or Substance Abuse Records	_____ Genetics (including test results)
_____ HIV/AIDS Test Results and Treatment	_____ Mental Health Records

This authorization shall be in force and effective for 6 months from the date of signature. I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to Retro Health, LLC. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.
I have read this form and agree to the uses and disclosures of the information as described. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____	Self_____	_____
Signature of Patient or Legal Representative	Relationship to Patient	Date

Retro Health, LLC

Notice of Privacy Practice

Your Information.
Your Rights.
Our Responsibilities.

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.

3900 N McColl Road, McAllen, TX 78501
Phone: (833) 420-9003 Fax: (956) 440-7020
Attention: Privacy Officer
Email: HIPAACOMPLIANCE@retrohealth.com

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice is effective November 1st. 2016

Right to Receive and Accounting of Disclosures: You have the right to request and "accounting" of certain disclosures that we have made of PHI about you during a specific period of up to 6 years. Other than disclosures made: for treatment, payment and health care operations; for us in or related to a facility directory; to you directly; pursuant to an authorization of you or your personal representative; for certain notifications purposes (including national security, intelligence, correctional, and law enforcement purposes); as incidental disclosures that occur as a result of otherwise permitted disclosures; as part of a limited data set of information that does not directly identify you; and before April 14, 2003. If you wish to make such a request, please contact our Privacy Official at the address or email listed on the first page of this Notice. The first list that you request in a 12-month period will be free, but we may charge you for a reasonable cost of providing additional lists in the same 12-month period. We will tell you about these costs, and you may choose to cancel your request at any time before costs are incurred.

Certain PHI will not be released without special permission from your part, as indicated on our "Release of Information" form. These are: Substance, Genetics, Psychiatric/Mental* and HIV Information.

*Be advised that we do not create or manage a hospital directory, and we do not create or maintain psychotherapy notes at this practice.