

## GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**A.** By signing this General Authorization for Release of Medical Records, you are authorizing your medical care provider, Park Medical Associates and Park Medical Laboratory, to disclose the information in your medical records to the extent needed for **treatment, payment, and health care operations**.

1. We will use your health information for the purpose of providing **treatment** to you. This would include, for example, sharing information with our employees, or with other health care providers who are treating you or consulting in your care. Also, we may request and use your prescription medication history from other healthcare providers or 3<sup>rd</sup>-party pharmacy benefit payors for treatment purposes.

2. We will use your health information for the purpose of arranging **payment** for your care. This would include, for example, your insurer or other third-party payor who is responsible for paying all or part of the cost of your care. The information on or accompanying your bill may include information that identifies you, as well as your diagnoses, medications, and procedures received.

3. We will use your health information for regular **health care operations**. This would include such things as internal audits and studies, evaluating provider performance, legal and medical review of care provided, business planning and management, customer service, filing, and resolutions of patient inquiries.

**B.** You may have the occasion to sign a Specific Authorization for Release of Medical Records that would authorize your provider to make a specific disclosure that is not covered under section A, above. A Specific Authorization would name the party to whom you are authorizing disclosure, and would contain any limitations on the authority to disclose your records.

**C.** You may revoke the General Authorization to use or disclose your health information except to the extent that action has already been taken by giving your provider a written notice of revocation. We may refuse to treat you if you revoke this General Authorization.

**D.** We may be required by law, in some cases, to make disclosures of your record that you have not authorized. Examples are subpoenas or court orders in criminal or civil litigation, or requests/surveys by licensure agencies or the U.S. Department of Health and Human Services.

**E.** 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.

**F.** Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it; the information belongs to you. You have the following rights with respect to your medical records/information:

1. You have the right to request restrictions on the use and disclosure of your medical records/information; however, we are not required to agree to restrictions that are not guaranteed by law. You will be informed if we will not agree to a requested restriction.

2. You have the right to receive confidential communications of your health information and to request communication of your health information by alternative means or at alternative locations. We must notify you if we are unable to accommodate your request.

3. You have the right to inspect and obtain a copy of your medical records. We reserve the right to charge you a reasonable fee related to the cost of copying your records.

4. You have the right to request amendments to your medical records, and if we do not agree with your request, you may note your objection in the medical record.

5. You have the right to receive an accounting (list) of the disclosures of your medical records/information made by us (except for those disclosures that fall within the scope of our health care operations or disclosures made for payment or treatment purposes).

6. You have the right to receive a paper copy of this Notice and General Authorization.

**G.** If you as a patient or guardian believe that your privacy rights have been violated, you may complain to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate in any way against a patient for making a complaint.

**H.** If you as a patient or guardian believe that your privacy rights have been violated, and you wish to complain to the physicians of Park Medical Associates, please write us with the details or call our office and ask to speak with our designated Privacy Officer, Sally Finkel (410) 583-7101.

**I.** We reserve the right to change our privacy practices, and to make the new policies effective for all protected health information that we maintain. Patients will be provided with revised notices, as appropriate.

We trust that you are comfortable with our sincere efforts to maintain the confidentiality of the information related to your medical care. Please acknowledge receipt and review of this notice and general authorization by signing below. For further information, please call Sally Finkel, at (410) 583-7101.

\_\_\_\_\_  
Name of Patient (printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Acct. #

Signature of Patient or Lawfully Authorized Representative: \_\_\_\_\_