



Please Circle all that Apply:

Constitutional:

Fatigue
Fever
Weakness
Weight Gain
Weight Loss

Musculoskeletal:

Pain - Left, Right or Both
Spasm - Left, Right or Both
Weakness - Left, Right or Both

Vision:

Blurred vision: Left, Right or Both

Skin:

Breast Lumps
Rash

Nose/Mouth/Throat:

Hoarseness
Smell or Taste
Vertigo
Snoring
Other

Gastroenterology:

Abdominal pain
Anorexia
Constipation

Hematologic/Lymphatic:

Anemia
Other

G.U.:

Frequent Urination
Urgent Urination
Incontinence

Endocrine:

Thyroid, High or Low
Diabetes

Neurology:

Dizziness
Headaches
Memory
Tremor
Numbness - Left or Right side or Both
Sleep / Insomnia / Snoring

Psychiatric:

Anxiety
Depression
Hallucinations

Cardiology:

Chest Pain
Palpitation

Balance/Motor Skills: In the past year, have you had any falls? ____ YES ____ NO

If yes, how many? _____

Hospitalization/Surgeries: Have you been hospitalized or had surgery since your last visit? ____ YES ____ NO

If yes, please explain: _____

Worsening:

Have any of your symptoms become worse? _____

Any New Problems? ____ YES ____ NO If yes, please explain: _____





Name: _____

Date of birth: _____

Are you currently under the care of a **Hospice Provider** or a **Skilled Nursing Facility**?

_____ YES PLEASE CIRCLE: HOSPICE or SKILLED NURSING FACILITY

_____ NO

Name of Facility: _____

Admitting Physician: _____

Date of Admission: _____

Admitting Diagnosis: _____

If **YES**, please notify front staff immediately.

If **NO**, please give this form to your provider's Medical Assistant before your appointment.



Notice of Health Information Privacy Practices

Effective September 23, 2013



This notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully.

Thank you for choosing the Medical Center Clinic for your healthcare needs. Each time you visit one of our providers, we create a record of the care and services you receive to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of your records of your care received by a provider at Medical Center Clinic and explains how we may use and disclose your health information as well as your rights regarding the health information we maintain about you.

We are required by law to make sure that health information that identifies you is kept private; give you this Notice of our legal duties and privacy practices with respect to your health information; and follow the terms of the Notice currently in effect. We reserve the right to change our privacy practices and this Notice at any time.

WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN PERMISSION IN THE FOLLOWING CIRCUMSTANCES:

Treatment: We will use and disclose your health information to provide medical treatment to you, and to coordinate or manage your health care related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example, we may use and disclose your health information when you need a prescription, lab work, an x-ray or other health care services. Also, we may use and disclose your health information when referring you to another health care provider.

Payment: We may use and disclose your health information to bill and receive payment. For example: A bill may be sent to you or your insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

Operations: We may use and disclose health information about you for health care operations. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including compliance program activities and business planning.

Business Associates: We may disclose your health information to our Business Associates to carry out treatment, payment or health care operations. For example, we may disclose health information about you to a company who bills insurance companies on our behalf to enable that company to help us obtain payment for the services we provide.

Appointment Reminders, Treatment Alternatives or Health-Related Services: We may contact you to provide appointment reminders, tell you about health-related services, to recommend possible treatment options or alternatives that may be of interest to you.

Research: We may use and disclose information to researchers or to collect information in databases used for research. Research projects are reviewed and approved by a Review Board to protect the privacy of your health information.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Military and Veterans: If you are a member of the armed forces, or separated or discharged from the military services, we may disclose your health information as required by national military command authorities or the Department of Veterans Affairs.

Public Health: We may disclose your health information to a public health authority that is permitted by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability.

Correctional Institution: If you are an inmate of a correctional institution, we may disclose to the institution or agents thereof, health information necessary to provide you with healthcare; to protect your health and

Medical Center Clinic

Notice of Health Information Privacy Practices

Effective September 23, 2013

safety or the health and safety of other individuals; or for the safety and security of the correctional institution.

Law Enforcement: We may disclose health information in response to a valid subpoena, warrant, summons or similar process. We may also release information for purposes of locating a suspect, a fugitive, a material witness, or missing person.

Health Oversight Activities: Federal law makes provisions for your health information to be released to an appropriate health oversight agency for activities such as audits, investigations, and inspections. This includes government agencies that oversee the healthcare system, government benefit programs, other government regulatory programs, and the civil rights laws.

SPECIAL CIRCUMSTANCES

Florida Privacy Laws: Health information related to substance abuse, mental health, or sexually transmissible diseases have special privacy protections in Florida. We will not disclose health information relating to substance abuse, mental health, or sexually transmissible disease unless: 1) the patient consents in writing, or 2) a court order requires disclosure of the information, or 3) medical personnel need information to meet a medical emergency, or 4) qualified personnel use the information for the purpose of conducting scientific research, management audits, financial audits or program evaluation, or 5) it is necessary to report a crime or a threat to commit a crime, or 6) to report abuse or neglect as required by law.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or law that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your revocation. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights with respect to your health information:

Right to Inspect and Copy Your Health Information: You have the right to see and obtain copies of health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

Right to Amend: If you think that health information we have about you is incorrect or incomplete, you may ask us to correct or add to the information, but we are not required to agree to the requested amendments.

Right to an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures of your protected health information.

Right to Request Restrictions: You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment or health care operations, but we are not required to agree to the requested restrictions.

We will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to your health plan for purposes of carrying out payment or your health plan's operations; and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

Right to Request Confidential Communications: You have the right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Right to Breach Notification: You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to Obtain a Copy of This Notice: You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

QUESTIONS OR COMPLAINTS

If you have questions about this Notice, or believe that your privacy rights have been violated, please contact Sharon Hoyle, CHC, CHPC, CPC, Corporate Compliance and Privacy Officer toll free at 1-866-822-3571, by e-mail at privacy.officer@medicalcenterclinic.com, or by U.S. Mail at:

Medical Center Clinic
Attn: Sharon Hoyle, Corporate Compliance and Privacy Officer
8333 N. Davis Hwy
Pensacola, FL 32514

You have the right to file a written 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.

Medical Center Clinic
Authorization to Release Medical Records



Fax completed form to 850.474.8022 or bring to Release of Information (1st Floor, Bldg 1).

PATIENT INFORMATION	Name:			Date of Birth:		
	Address:			Daytime Phone:		
	City:			State:		Zip:
	Email:			Date Submitted:		
MEDICAL CENTER PROVIDER List the MCC providers for which you want records sent.	☐ ALL ☐ NON-MCC PROVIDER (specify provider below)					
	1)			Specialty		
	2)			Specialty		
	3)			Specialty		
RECEIVING PARTY <i>Where</i> do you want the information sent? <i>Who</i> do you want to have the information?	☐ Self Complete All Sections Below For Proper Delivery					
	Name:			Phone No.:		
	Address:			Fax No.:		
	City:			State:		Zip:
	Attention to:					
INFORMATION TO BE RELEASED <i>What</i> do you want sent or released? Check the appropriate box.	Type of Record	Start Date	End Date	Type of Record	Start Date	End Date
	☐ ALL MCC records			☐ Operative Report		
	☐ Billing			☐ Pathology		
	☐ IV Therapy			☐ Physical Therapy		
	☐ Lab			☐ Office Note		
	☐ Mental Health			☐ Radiology		
	☐ Neurodiagnostic			☐ Sleep Study		
RELEASE and DELIVERY INSTRUCTIONS <i>How</i> and <i>When</i> do you want the information delivered?	Date record is needed: _____ (NOTE: Allow 7-10 business days for processing)					
	FORM OF MEDIA FOR DELIVERY OF RECORDS (If left blank, a paper copy will be provided)					
	☐ Paper (USPS Mail or Pick-up)			☐ USB Drive, CD/DVD (pre-payment required)		
	☐ Fax (to Fax No. of Receiving Party Above)			☐ Encrypted email to this email address: _____		
*NOTE: In the event MCC is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when Receiving PHI in electronic format or email.						
PURPOSE OF RELEASE Why is it needed?	☐ Treatment (Patient Care) ☐ Litigation/legal** ☐ Personal**					
	**Pursuant to F.S. 452 and Federal Rule 45 C.F.R. §164.524, a fee of \$1.00 per page for the first 25 pages and .25 per page thereafter plus applicable shipping may be charged.					

- This authorization may be canceled in writing at any time. A cancellation will not change releases that happen before the cancellation. Medical Center Clinic's (MCC) Notice of Privacy Practice describes how to cancel (revoke) this authorization.
- MCC will not restrict my treatment if I choose not to sign this authorization.
- A photocopy, fax, or scanned image of this authorization will be treated in the same way as the original.
- MCC records may include records that it received from other organizations. If these records have been used by MCC and filed in the record MCC maintains about you, these records may be released with your MCC records.
- MCC cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization and that information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release MCC from any and all liability resulting from a re-disclosure by the recipient.

Signing (or typing) your name below indicates you have read and understand this form, and authorize, or are authorized, to release the information as requested above.

 Patient/Legal Representative Signature

 Authority to act on behalf of patient (attach document)

SUBMIT

Medical Center Clinic
Authorization to Release Medical Records

Directions for Completion of Form

Patient Information: Complete the entire section which identifies clearly and legibly all of the demographic information specific to the patient (individual who information is being requested for)

Provider: Identify which MCC provider you are seeking information from (or to be sent to). **Please be specific** in your request. If you do not identify a specific provider, records may be provided for **ALL** MCC providers from whom you have received care. Visit www.medicalcenterclinic.com/providers for a listing of all MCC's providers.

Receiving Party: Identify the full name/business, address, phone and contact information for the name of the individual who is *to receive* the information. ***Please allow 7-10 days for all requests to be processed and sent to the recipient.***

Information to Be Released: This section gives us the instructions for what information you want released. If you select mark a specific type of record, such as physical therapy, we will provide only those records. If you select "ALL records", your entire record will be provided for a specific visit date or all dates. It is very helpful if you identify the date or range of dates, needed by the requestor.

Release and Delivery Instructions: This tells us how you would like your information delivered. We can print the records, send the records by fax, or provide your records in electronic format. Electronic records can be stored on a USB drive or e-mailed to the recipient. Radiology images will be provided on CD.

Purpose of Request: Please identify why you need a copy of your record. This helps us to track and assign a priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

Duration of consent, revocation and other information you need to know: This consent will automatically expire in 12 months **unless** you write some other date or event. You may indicate the consent is valid "5 years", "10 years", but there needs to be an ending date. The authorization is revoked at your written direction to MCC's Release of Information Department.

This form can be faxed to 850.474.8022 or delivered to the ROI department located on the first floor of building 1, across from the Diagnostic Center. Office Hours are Monday through Friday 8:00a.m. to 4:00p.m. (closed daily for lunch, 12:00 to 1:00).