HIPAA COMPLIANT PATIENT AUTHORIZATION FORM

I, _____ understand that under portability and accountability Act of 1966 (HIPAA), I have certain rights to privacy regarding my health information. I also understand that Calderon Medical Group originates and maintains paper and/or electronic records describing my health history, symptoms, examinations, test results, labs, pathology reports, hospital records, diagnostic imaging, radiology reports, diagnosis, treatment and any plans for future care and treatment. I understand that this information can be used as:

A basis for planning my care and treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly or indirectly.

A means of communication among the many health professionals who contribute to my care.

A means by which a third-party payer can verify that services billed were actually provided and obtain payment from the various insurance payers.

A tool for routine healthcare operations such as assessing quality and receiving the competence of healthcare professionals.

Person working for or entity requesting the information and authorized to make the requested use of or the disclosure of information:

Calderon Medical Group
3000 West Charleston Blvd. #1 & #5 Las Vegas, NV 89102

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the above addresses.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA.
- I may refuse to sign this authorization and that this will not constitute non- treatment or payment on me because of the non signature(except to the extent that the authorization is for research-related treatment , in which case you may refuse to provide that research-related treatment only).
- I understand that you will receive compensation from a third party for the use or disclosure of my information.
- I have had ample opportunity to ask questions as it relates to HIPAA information.

Patient Name:_____ Date of Birth:_____

Date Completed:_____