SE
FAMILY HEALTHCARE
JONESVILLE

Welcome t o Jonesville Family Healthcare! We are honored that you have chosen us f or your healthcare needs and the needs of your family. Rebecca Sigler, FNP is trained and board certified in family medicine and is a preferred provider for most major insurance companies. Our mission is to provide you prompt, compassionate and courteous care. We are committed to providing access to high quality medical care in Jonesville, Louisiana.

Below are a few of our office policies:

- We can be reached by calling the office number after hours, 7 days a week, 24 hours a day. This answering service is for your convenience only. If you cannot get in touch with our staff after hours, and you have a medical emergency you are to proceed to the nearest Emergency Room or call 911.
- Routine medication refills will be done during office hours only. Please provide a 24 hour notice for ALL refills.
- You will be reminded of your upcoming appointment one day prior. If your appointment is confirmed by yourself or a family member, you are expected to keep your appointment. Failing to do so will result in a $25 fee.
- Patients are seen by scheduled appointments, but walk-ins are welcome. Rebecca Sigler, FNP will make every effort to accommodate your healthcare needs.

Office hours are as follows:
Monday-Thursday 8am-4:30pm
Friday 8am-12pm

Patient signature upon Agreement _____ Date _____

Patient Information

First Name _____ M ____ Last Name _____

Date of Birth _____ Sex M F Race _____ Social Security # _____-____-_____

Mailing Address _____ City _____ State ____ Zip_____

Home Phone (_____)_____ Cell Phone (_____)_____Work Phone (_____)_____

Emergency Contact Name _____ Phone (____)_____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employment ☐ Employed ☐ Retired ☐ Unemployed ☐ Other

Employer _____ Employer Phone (_____)_____

Guarantor Information (Person Responsible for Payment) ☐ SAME AS PATIENT

First Name _____Last Name_____ Date of Birth_____

Social Security # _____ -____- _____ Sex M F Phone (_____)_____

Mailing Address _____City _____ State _____ Zip_____

Relationship to Patient _____

Primary Insurance

Insurance Company _____ Phone (_____)_____

☐ ***SAME AS PATIENT*** Policy Holder Name _____ Date of Birth _____

Social Security # _____-____-_____ Relationship to Patient _____

Insurance ID # _____ Group # _____

Secondary Insurance

Insurance Company _____ Phone (_____)_____

☐ ***SAME AS PATIENT*** Policy Holder Name _____ Date of Birth _____

Social Security # _____-____-_____ Relationship to Patient _____

Insurance ID # _____ Group # _____

PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE PROVIDER AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES AND OTHERS PAY A PERCENTAGE OF THE CHARGE. IT IS **YOUR RESPONSIBILITY** TO PAY ANY DEDUCTIBLE AMOUNT, COINSURANCE, OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE.

Signature of Patient/ Guardian_____ Date_____

HEALTH HISTORY

SE FAMILY HEALTHCARE JONESVILLE

Patient Name: _____ Today's Date: _____

Age: _____ Birthdate: _____ Date of last Physical Examination: _____

What is your reason for visit? _____

SYMPTOMS check (√) symptoms you currently have or have had in the past year

GENERAL

- □ chills
- □ depression
- □ dizziness
- □ fainting
- □ fever
- □ forgetfulness
- □ headache
- □ loss of sleep
- □ loss of weight
- □ nervousness
- □ numbness
- □ sweats

GASTROINTESTINAL

- □ appetite poor
- □ bloating
- □ bowel changes
- □ constipation
- □ diarrhea
- □ excessive hunger
- □ excessive thirst
- □ gas
- □ hemorrhoids
- □ indigestion
- □ nausea
- □ rectal bleeding
- □ stomach pain
- □ vomiting
- □ vomiting blood

EYE, EAR, NOSE, THROAT

- □ bleeding gums
- □ blurred vision
- □ crossed eyes
- □ difficulty swallowing
- □ double vision
- □ earache
- □ ear discharge
- □ hay fever
- □ hoarseness
- □ loss of hearing
- □ nosebleeds
- □ persistent cough
- □ ringing in ears
- □ sinus problems
- □ vision – flashes
- □ vision – halos

MEN ONLY

- □ breast lump
- □ erection difficulties
- □ lump in testicles
- □ penis discharge
- □ sore on penis
- □ other

WOMEN ONLY

- □ abnormal pap smear
- □ bleeding between periods
- □ breast lump
- □ extreme menstrual pain
- □ hot flashes
- □ nipple discharge
- □ painful intercourse
- □ vaginal discharge
- □ other

- •Date of last menstrual period_____
- •Date of last Pap Smear _____
- •Had a mammogram?____
- •Are you pregnant?_____
- •Number of children_____

MUSCLE/JOINT/BONE

pain, weakness, or numbness:

- □ arms
- □ back
- □ feet
- □ hands
- □ hips
- □ legs
- □ neck
- □ shoulders

CARDIOVASCULAR

- □ chest pain
- □ high blood pressure
- □ irregular heart beat
- □ low blood pressure
- □ poor circulation
- □ rapid heart beat
- □ swelling of ankles
- □ varicose veins

SKIN

- □ bruise easily
- □ hives
- □ itching
- □ change in moles
- □ rash
- □ scars
- □ sore that wont heal

GENITO-URINARY

- □ blood in urine
- □ frequent urination
- □ lack of bladder control
- □ painful urination

CONDITIONS check (√) symptoms you currently have or have had in the past year

- □ AIDS
- □ alcoholism
- □ anemia
- □ anorexia
- □ appendicitis
- □ arthritis
- □ asthma
- □ bleeding disorders
- □ breast lump
- □ bronchitis
- □ polio
- □ chemical dependency
- □ chicken pox
- □ diabetes
- □ emphysema
- □ epilepsy
- □ glaucoma
- □ goiter
- □ gonorrhea
- □ gout
- □ heart disease
- □ venereal disease
- □ high cholesterol
- □ HIV positive
- □ kidney disease
- □ liver disease
- □ measles
- □ migraine headaches
- □ miscarriage
- □ mononucleosis
- □ multiple sclerosis
- □ mumps
- □ prostate problem
- □ psychiatric care
- □ rheumatic fever
- □ scarlet fever
- □ stroke
- □ suicide attempt
- □ thyroid problems
- □ tonsillitis
- □ tuberculosis
- □ typhoid fever
- □ bulimia
- □ hepatitis
- □ pacemaker
- □ ulcers
- □ cancer
- □ hernia
- □ pneumonia
- □ vaginal infections
- □ cataracts
- □ herpes

MEDICATIONS list medications you are currently taking	**ALLERGIES** to medications or substances

PHARMACY NAME & LOCATION

_____

ALL INFORMATION IS STRICTLY CONFIDENTIAL

FAMILY HISTORY fill in health information about your immediate family

Relation	Age	State of Health	Age at Death	Cause of Death
FATHER				
MOTHER				
BROTHERS				
SISTERS				

Check if your blood relatives had any of the following

	DISEASE	RELATIONSHIP TO YOU
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Stroke	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

YEAR	HOSPITAL	REASON FOR HOSPITALIZATION

PREGNANCY HISTORY

YEAR OF BIRTH	SEX	COMPLICATIONS, IF ANY

Have you ever had a blood transfusion? □YES □NO

If yes, please give approximate dates:_____

SERIOUS ILLNESS/INJURY	DATE	OUTCOME

HEALTH HABITS

check which substances you use & describe how much you use

	CAFFEINE	
	TOBACCO	
	STREET DRUGS	
	OTHER	

OCCUPATIONAL CONCERNS

CHECK IF YOUR WORK EXPOSES YOU TO THE FOLLOWING:

	STRESS
	HAZARDOUS SUBSTANCES
	HEAVY LIFTING
	OTHER

YOUR OCCUPATION:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of patient, parent, guardian or personal representative — Date

_____ _____

Please print name of patient, parent, guardian or personal representative — Date

AUTHORIZATION AND RELEASE

I, the undersigned, have insurance coverage with (Name of Insurance Company) _____ _____ and assign directly to Jonesville Family Healthcare all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

___(Initial) I understand that my provider may require in the course of my treatment that I have lab work, radiology, diagnostics, and/or other procedures and etc. that will be performed by offices other than Jonesville Family Healthcare and that they will send me statements from their offices and Jonesville Family Healthcare is in no way responsible for their billing practices.

PRESCRIPTION HISTORY CONSENT

___(Initial) I agree that the clinic may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payers for treatment purposes.

MEDICARE AUTHORIZATION

___(Initial) I request that payment of authorized Medicare benefits be made to Jonesville Family Healthcare on my behalf for any services furnished to me by the provider. I authorized any holder of medical information about me to be released to the health care financing administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary/Patient Signature Date

Notice of Privacy Practice

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Facility is required by law to provide you with this Notice so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" ("PHI") or simply "health information." We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please contact (318) 657-2273.

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you are admitted to our Facility, a record of your stay is made containing health and financial information. Typically, this record contains information about your condition, the treatment we provide and payment for the treatment. We may use and/or disclose this information to:

- plan your care and treatment
- communicate with other health professionals involved in your care
- document the care you receive
- educate health professionals
- provide information for medical research
- provide information to public health officials
- evaluate and improve the care we provide
- obtain payment for the care we provide

Understanding what is in your record and how your health information is used helps you to:

- ensure it is accurate
- better understand who may access your health information
- make more informed decisions when authorizing disclosure to others

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe the ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall into one of the categories.

- **For Treatment**. We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to doctors, nurses, therapists or other Facility personnel who are involved in taking care of you at a Facility. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can plan your meals. Different departments of a Facility also may share health information about you in order to coordinate your care and provide you medication, lab work and x-rays. We may also disclose health information about you to people outside the Facility who may be involved in your medical care after you leave a Facility. This may include family members or visiting nurses to provide care in your home.

- **For Payment**. We may use and disclose health information about you so that the treatment and services you receive at a Facility may be billed to you, an insurance company or a third party. For example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

- **For Health Care Operations.** We may use and disclose health information about you for our day-to-day health care operations. This is necessary to ensure that all residents receive quality care. For example, we may use health information for quality assessment and improvement activities and for developing and evaluating clinical protocols. We may also combine health information about many residents to help determine what additional services should offer, what services should be discontinued, and whether certain new treatments are effective. Health information about you may be used by our corporate office for business development and planning, cost management analyses, insurance claims management, risk management activities, and in developing and testing information systems and programs. We may also use and disclose information for professional review, performance evaluation, and for training programs. Other aspects of health care operations that may require use and disclosure of your health information include accreditation, certification, licensing and credentialing activities, review, and auditing, including compliance reviews, medical reviews, legal services and compliance programs. Your health information may be used and disclosed for the business management and general activities of the Facility including resolution of internal grievances, customer service and due diligence in connection with a sale or transfer of the Facility. In limited circumstances, we may disclose your health information to another entity subject to HIPAA for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of residents. We may disclose your age, birth date and general information about you in the Facility newsletter, on activities calendars, and to entities in the community that wish to acknowledge your birthday or commemorate your achievements on special occasions. If you are receiving therapy services, we may post your photograph and general information about your progress.

OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION

- **Business Associates**. There are some services provided in our Facility through contracts with business associates. Examples include medical directors, outside attorneys, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

- **Providers**. Many services provided to you, as part of your care at our Facility, are offered by participants in one of our organized healthcare arrangements. These participants include a variety of providers such as physicians (e.g., MD, DO, Podiatrist, Dentist, Optometrist), therapists (e.g., Physical therapist, Occupational therapist, Speech therapist), portable radiology units, clinical labs, hospice caregivers, pharmacies, psychologists, LCSWs, and suppliers (e.g., prosthetic, orthotics).

- **Treatment Alternatives**. We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.

- **Health-Related Benefits and Services and Reminders**. 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.

- **Fundraising Activities**. We may use health information about you to contact you in an effort to raise money as part of a fundraising effort. We may disclose health information to a foundation related to the Facility so that the foundation may contact you in raising money for the Facility. We will only release contact information, such as your name, address and phone number and the dates you received treatment or services at the Facility.

- **Facility Directory**. We may include information about you in the Facility directory while you are a resident. This information may include your name, location in the Facility, your general condition (e.g., fair, stable, etc.) and your religion. The directory information, except for your religion, may be disclosed to people who ask for you by name. Your religion may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in the Facility and generally know how you are doing.

- **Individuals Involved in Your Care or Payment for Your Care**. Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

- **As Required By Law**. We will disclose health information about you when required to do so by federal, state, or local law.

  - **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.

  - **Organ and Tissue Donation**. If you are an organ donor, we may disclose health information to organizations that handle organ procurement to facilitate donation and transplantation.

- **Military and Veterans**. If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.
- **Research**. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all residents who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with residents' need for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may, however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave a Facility.
- **Workers' Compensation**. We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Reporting** Federal and state laws may require or permit the Facility to disclose certain health information related to the following:
  - *Public Health Risks*. We may disclose health information about you for public health purposes, including:
    - Prevention or control of disease, injury or disability
    - Reporting births and deaths;
    - Reporting child abuse or neglect;
    - Reporting reactions to medications or problems with products;
    - Notifying people of recalls of products;
    - Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease;
    - Notifying the appropriate government authority if we believe a resident has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
  - *Health Oversight Activities*. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
  - *Judicial and Administrative Proceedings:* If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
  - *Reporting Abuse, Neglect or Domestic Violence:* Notifying the appropriate government agency if we believe a resident has been the victim of abuse, neglect, or domestic violence.

Law Enforcement. We may disclose health information when requested by a law enforcement official:

In response to a court order, subpoena, warrant, summons or similar process;

To identify or locate a suspect, fugitive, material witness, or missing person;

About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement;

About a death we believe may be the result of criminal conduct;

About criminal conduct at the Facility; and

In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities**. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Correctional Institution:** Should you be an inmate of a correctional institution; we may disclose to the institution or its agent's health information necessary for your health and the health and safety of others.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws 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 written authorization. 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 RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Although your health record is the property of the Facility, the information belongs to you. You have the following rights regarding your health information:

- **Right to Inspect and Copy**. With some exceptions, you have the right to review and copy your health information.

  You must submit your request in writing to 800 Audubon Drive, Jonesville LA 71343. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- **Right to Amend**. If you feel that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have this right for as long as the information is kept by or for the Facility.

  You must submit your request in writing to 800 Audubon Drive, Jonesville LA 71343. In addition, you must provide a reason for your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

  Is not part of the health information kept by or for the Facility; or

  Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of certain disclosures we made of your health information, other than those made for purposes such as treatment, payment, or health care operations.

You must submit your request in writing to 800 Audubon Drive, Jonesville LA 71343. Your request must state a time period which may not be longer than six years from the date the request is submitted and may not include dates before November 21, 2022. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you may request that we limit the health information we disclose to someone who is involved in your care or the payment for your care. You could ask that we not use or disclose information about a surgery you had to a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You must submit your request in writing to 800 Audubon Drive, Jonesville LA 71343. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Alternate Communications. You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box.

You must submit your request in writing to 800 Audubon Drive, Jonesville LA 71343. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time. To obtain a paper copy of this Notice, contact (318) 657-2273.

JONESVILLE FAMILY HEALTHCARE

AUTHORZATION AND CONSENT FOR MEDICAL TREATMENT, PAYMENT GUARANTEE, AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

GENERAL CONSENT FOR MEDICAL TREATMENT: As a patient of **JONESVILLE FAMILY HEALTHCARE, the Clinic**, I understand that the clinic has an obligation to provide screening and emergency medical treatment when appropriate and to provide appropriate care and treatment of all patients. I hereby authorize the clinic, and its affiliated physicians and other licensed providers to order and/or provide direct and indirect services in efforts to diagnose and treat diseases, disorders, injuries or other conditions. I understand that the providers will act in good faith to provide quality care and treatment. However, a specific cure or resolution cannot be promised. My patient rights include my participation in my care plans and treatment options. I may revoke this consent for general treatment. Additional informed consent shall be given for medical procedures or treatments for which I need to specifically consent.

REASSIGNMENT OF BENEFITS AND PAYMENT GUARANTEE: I authorize **the Clinic** to bill my insurance company or other designated third-party payer for the services provided as related to my care. I acknowledge that the clinic will file claims on my behalf as a courtesy and that I, as guarantor of the account, remain responsible for payment of services. I acknowledge that I am also responsible for deductibles, co-insurance amounts, co-payment amounts, and non-covered services. I/we agree to pay the established rates of the clinic for all services rendered for the patient named below. I also acknowledge that I am aware that the clinic may have policies for financial counseling and assistance.

RELEASE OF MEDICAL INFORMATION FOR TPO AND EMERGENCY CARE: I do hereby authorize **the Clinic** to release medical or other information to any insurance company or third-party for which reassignment of my benefits has been made for a medical service. I understand that my information may be released by law for any business activity related to the treatment, payment and operation (TPO) related to my care. I also authorize the healthcare providers of the clinic to release medical and other information to other healthcare providers or facilities as needed for emergency treatment or continuity of care. Unless otherwise restricted by the me, as patient or guardian, health information may also be released to immediate family members who are actively engaged in the management of my care. In all other cases, I understand that I will be required to authorize the release of protected health information (PHI) for any other reason.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT: By signing this form, I acknowledge receipt of the notice of privacy practices of **the Clinic.** Our notice of privacy provides information about how we may use and disclose your protected health information. We are required by federal law to obtain your acknowledgment that you have received this Notice. If you have any questions about our notice of privacy practices, please contact us at the above telephone number.

THE UNDERSIGNED CERTIFIES HE/SHE HAS READ AND UNDERSTANDS THE ABOVE INFORMATION AND AUTHORZATION. IT ALSO CERTIFIES YOU HAVE RECEIVED OUR NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS. THIS AUTHORIZATION/ACKNOWLEDGEMENT REMAINS IN FORCE UNTIL SUCH DATE THAT IT IS REVOKED OR REPLACED.

Patient Name:_____ Date of Birth_____

Parent/Guardian Signature: _____ Date: _____

Relationship of Signer to the Patient: ☐ Parent/Guardian ☐ Spouse ☐Grandparent ☐Other Relative

SE
FAMILY HEALTHCARE
JONESVILLE

AUTHORIZATION FOR MEDICAL RECORD INFORMATION RELEASE

(request can not be processed if all fields are not completed)

I, _____, do hereby authorize the release of the following records and/or information with limitations, which may include treatment of psychiatric illness, alcohol or drug abuse, HIV test results or AIDS diagnoses, and/or sexual preference. Review of the record is also authorized.

Patient Name _____

Date of Birth _____

Social Security # _____-____-_____

Street Address _____

City-State-Zip _____

Phone Number (_____)_____

Records Requested From:
Doctor _____
Address _____
_____
Phone _____
Fax _____

Records to be Sent To:
Doctor _____
Address _____
_____
Phone _____
Fax _____

Please release the following information:

___ ALL RECORDS	___ Radiology Reports	___ History & Physical
___ Face Sheet	___ Consultation Reports	___ Lab Reports
___ X-Ray Films/Reports	___ Pathology Reports	___ Operative Reports
___ Immunization Reports	___ Discharge Summary	___ Other (specify) _____

For the following time period _____ to _____

I understand that this authorization shall remain in affect for 90 days from the date of my signature unless an earlier expiration date is specified in the following space (_____). I also understand that except to the extent that actions are taken based on my authorizations, I may withdraw this authorization at any time by written notification to the parties involved. I further agree Jonesville Family Healthcare may charge me or my designated recipient's cost incurred in preparing copy of the requested medical records.

_____ _____
Signature of Patient/Parent/Guardian/Authorized Rep Date

_____ _____
Signature of Physician/Nurse/Office Employee that Witnessed Date

Jonesville Family Healthcare

800 Audubon Drive
Jonesville, LA 71343
Telephone: 318-657-2273

IMPORTANT: List all persons (family, friends, etc) that you authorize Jonesville Family Healthcare to release or speak with about your medical information. Please be aware anyone that is not listed will be unable to receive any of your information, written or verbal, from our clinic.

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Your Name (print):_____

Signature:_____

Date:_____