

**AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

- 1. Specific description of information that may be used/disclosed:  
\_\_\_\_\_
- 2. The information will be used/disclosed for the following purpose(s):  
\_\_\_\_\_  
\_\_\_\_\_
- 3. Persons/organizations authorized to use or disclose the information:  
\_\_\_\_\_  
\_\_\_\_\_
- 4. Persons/organizations authorized to receive the information:  
\_\_\_\_\_  
\_\_\_\_\_

5. The person/organization authorized to use/disclose the information will receive compensation for doing so. Yes \_\_\_ No \_\_\_

6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.

7. If the purpose of this authorization is for the use and/or disclosure of health information for a research study, and I refuse to sign this authorization, East Carolina Dermatology reserves the right to deny treatment associated with such research.

8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, East Carolina Dermatology reserves the right to deny that health care.

9. I understand that I may inspect or copy the information used or disclosed.

10. I understand that I may revoke this authorization at any time by notifying East Carolina Dermatology in writing, except to the extent that:

- a) action has been taken in reliance on this authorization: or
- b) if this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

11. I understand that I have a right to request and receive a Notice of Privacy Practices from East Carolina Dermatology.

12. This authorization expires on [upon] \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or patient's representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient or patient's representative representative's

\_\_\_\_\_  
Relationship to patient, or

authority to act for the patient, if applicable

**NOTICE OF PRIVACY PRACTICES**  
**EAST CAROLINA DERMATOLOGY, P.A.**  
Effective Date: April 14, 2003

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.

**I. OUR RESPONSIBILITIES**

East Carolina Dermatology, P.A. is required by law to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices. We are also required to let you know how you can obtain copies of any changes to our Notice, and to abide by the terms of the Notice that is currently in effect. We reserve the right to change this Notice and our privacy policies at any time. Any such changes will apply to the protected health information we already have. When we make an important change to our policies, we will post the new Notice in our waiting areas. You can receive a copy of the current Notice by contacting our Privacy Officer.

**II. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED INFORMATION**

We will share medical information about you with each other as necessary to provide you with health care, to obtain payment for that health care, and to operate our business effectively. We may also use and disclose medical information about you for a number of different purposes, which we describe below. For each of the categories of uses or disclosures described, we will explain what we mean and try to give an example. Not every use or disclosure in a category will be listed; however, all of the ways we are permitted to use and disclose your health information will fall within one of the categories.

**A. Treatment, Payment & Health Care Operations**

1. **Uses and Disclosures of Your Protected Health Information for Treatment That Purposes That Do Not Require Your Prior Written Consent.** We may use and disclose your protected health information in order to provide, coordinate, or manage your health care and related services without obtaining your prior written consent. This means that we can share your protected health information with all of the health care personnel who are involved in your care for these purposes. For example, if Dr. Klein refers you to a specialist for testing and treatment, we can share your protected health information with that specialist. Similarly, we may share your health information with a pharmacy when calling in a prescription.
2. **Uses of Your Protected Health Information for Payment Purposes That Do Not Require Your Prior Written Consent.** We may use protected health information about you to arrange for payment of our services. For example, our billing, accounts receivable and collections employees may access your protected health information for this purpose.
3. **Disclosures of Your Protected Health Information for Payment Purposes That Require your Prior Written Consent.** North Carolina law requires us to get your written consent to disclose your protected health information for payment purposes. If you are an existing patient, you have already signed a consent allowing us to share your protected health information with your health insurance company (or any other person or entity responsible for paying for your health care services) for payment purposes. If you are a new patient, we will ask you to sign a consent during your first visit with us after April 14, 2003. Other than an emergency situation, we can refuse treatment to any patient who does not sign a consent allowing us to share protected health information with his or her insurance company or any other person or entity responsible for paying for your health care services. For example, after obtaining your consent, we may share portions of your medical record with your insurance company to ask about coverage under your plan, and for approval of payment before we provide services to you.
4. **Uses of Your Protected Health Information for our Health Care Operations That Do Not Require Your Prior Consent.** We may use your protected health information for a variety of business activities that we call "health care operations". We make these uses so that we can improve the quality of care we provide and to reduce health care costs. For example, we may access your protected health to evaluate the skills of the nurse who provides services to you at our office.
5. **Disclosures of your Protected Health Information for our Health Care Operations That Require Your Prior Written Consent.** North Carolina law requires us to get your written consent to the disclosure of your protected health information for our health care operations. You will be asked to sign a consent during your first visit with us after April 14, 2003. In other than an emergency situation, we can refuse treatment to any patient who does not sign a consent allowing us to share protected health

- B. If you have one of several specific communicable diseases (for example, tuberculosis or HIV/AIDS), information about your disease will be treated as confidential, and will be disclosed without your written permission only in limited circumstances. For example, we will obtain your permission to report information for payment purposes. However, we may not need to obtain your permission to report information about your communicable disease to State and local officials or to otherwise use or release information in order to protect against the spread of the disease. We must disclose health information if Dr. Klein believes that a client has a communicable disease or is infected with HIV and is not following safety measures.

#### IV. YOUR HEALTH INFORMATION RIGHTS

Although your health record is the property of and belongs to East Carolina Dermatology, P.A., you have the following rights with respect to your protected health information:

- A. **The Right to Request Restrictions on Uses and Disclosures of Your Protected Health Information.** You have the right to ask us to limit how we use and disclose your protected health information. We will consider your request, but we are not legally required to accept it. If we do accept your request, we will note the accepted limitations in writing and follow those restrictions except in emergency circumstances. You may not limit the uses and disclosures that we are legally required to make.
- B. **The Right to Choose How We Send Protected Health Information.** You have the right to ask that we send information to you to an alternate address (for example, to your home address instead of your work address), or by alternative means (for example, by e-mail instead of regular mail). If we can easily provide the information in the format you request, then we must agree to your request and abide by it.
- C. **The Right to See and Get Copies of Your Protected Health Information.** In most cases you have the right to look at or get copies of your protected health information. You must make any request to look at or get copies of your protected health information in writing to our Privacy Officer. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we deny your request, we must tell you, in writing, our reasons for denying your request and explain to you that you have the right to have our decision reviewed and how to start the review process. If you request copies of your protected health information, we will charge \$.\_\_\_\_ for each page. Instead of providing the information, we may provide you with a summary or explanation and ask you to pay the cost of it in advance.
- D. **The Right to Get a List of Disclosures We Have Made.** You have the right to get a list of the persons or entities with whom we have shared your protected health information outside of our practice; however, we are not required to list the following disclosures:
1. Disclosures we made for treatment, payment or health care operations;
  2. Disclosures for which you have signed a consent or authorization;
  3. Disclosures we made to you or to a family member or friend to which you did not object;
  4. Disclosures for national security or intelligence purposes;
  5. Disclosures to correctional institutions or law enforcement officials;
  6. Incidental disclosures made in connection with a permitted use or disclosure; or
  7. Disclosure made prior to April 14, 2003.

You must make any requests for a list of disclosures in writing to our Privacy Officer. We will respond to you within 60 days after receiving your written request. The list we give you will include disclosures of your protected health information that have been made by us or our business associates during the 6 years prior to your request unless you request a shorter period. The list will include the date of each disclosure, the name and address (if known) of the person or entity to whom the disclosure was made, a description of the information disclosed, and the reason for the disclosure. If we are unable to provide a list within 60 days following your request, we will let you know in writing before the end of those 60 days that we are unable to do so and will provide the list to you no later than 90 days following our receipt of your request for the list. We will provide this list to you at no charge; however, if you request more than one list during any 12-month period, we will charge \$10 for each additional list requested during that period.

**E. The Right to Correct or Update Your Protected Health Information.** If you believe there is a mistake in your protected health information or that a piece of important information is missing, you have the right to ask us to correct the information or add the missing information to your record. You must make a request for us to the information in writing to our Privacy Officer, on the forms we will provide to you. Your request must include a reason for the change you are proposing we make to your information. We will respond within 60 days after receiving your written request. We may deny your request in writing if:

1. The information we have is correct and complete;
2. The information you want to change was not created by us;
3. The information you want to change is information which you would not be allowed to look at or copy by law;
4. The information you want to change is not a part of our records.

Our written denial will include the reason we are denying your request and will explain your right to file a written statement of disagreement with the denial, including the forms used to make such a filing. If you do not file a written statement of disagreement, you have the right to ask us, in writing, to attach your initial request and our denial to all future disclosures of the affected information. If you do not make such a request, we are not required to include the request and denial with any future disclosures. If you do file a written statement of disagreement, we have the right to prepare and provide a written rebuttal to your statement. Thereafter, we must include your initial request, our denial, your written statement of disagreement and our rebuttal whenever we disclose the affected information. If we approve your request, we will make the requested change to your information, tell you that we have made the change and get a list from you of other persons who need the changed information, and then notify those persons you have identified, as well as those of whom we are aware, who need to know about the change of your information. If we are unable to respond to you within 60 days following your request, we will let you know in writing before the end of those 60 days that we are unable to do so and will provide our response to you no later than 90 days following our receipt of your request for the change.

**F. The Right to Obtain a Paper Copy of this Notice.** You have the right, at any time, to get a paper copy of this notice, even if you have agreed that we may provide the notice and any changes to you via e-mail or other electronic means. To obtain a paper copy of this notice, please contact our Privacy Officer.

**V. IF YOU HAVE QUESTIONS OR WANT TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**

If you have questions about or think we have violated your privacy rights or if you disagree with a decision we made about access to your protected health information, you may file a complaint by contacting our Privacy Officer at (252) 633-4200.

You may also send a written complaint to the United States Department of Health and Human Services by sending your complaint to:

Office for Civil Rights  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

We will not take adverse action against you for filing a complaint.

information for our health care operations. For example, after obtaining your consent, we may share protected health information about you with our accountants, lawyers, and others who assist us in complying with this Notice and other applicable laws.

**B. Certain Other Uses and Disclosures That Do Not Require Your Prior Written Consent.** We may use and disclose your protected health information without your consent or authorization for the following reasons:

1. **When disclosure is required by federal or local law, judicial or administrative proceedings, or law enforcement.** We will disclose protected health information when a law requires us to report information to a government agency, to a law enforcement agency, or when we receive a valid court order or subpoena. We also will disclose information when we suspect abuse or neglect of a child or disabled adult.
2. **When the use and/or disclosure is for health oversight activities.** We may disclose medical information about you to a health oversight agency. For example, a government agency may request information from us while reviewing whether we are in compliance with the various laws and regulations that we must comply with.
3. **For public health activities or to avert a serious threat to health and safety.** We may report information about certain diseases to the local health department, and we may provide information to law enforcement or another person if we believe, in good faith, that the use or disclosure is necessary to prevent serious and imminent threat to the health or safety of a person or the public.
4. **For specialized government functions.** We may disclose protected health information to authorized federal officials for the conduct of lawful intelligence, counterintelligence and other national security activities authorized by law.
5. **For workers' compensation.** In the event your visit is related to a workers' compensation claim, we may disclose protected health information about you in order to comply with workers' compensation laws.
6. **Appointment reminders and health related benefits or service.** We may use your protected health information to remind you that you have an appointment with us, or to tell you about treatment alternatives or other health care services we offer.
7. **Uses and Disclosures Where You Have the Opportunity to Object.** We may provide protected health information to your family members, a friend or other person that you indicated is involved in your care or the payment of your health care, unless you object. In emergency situations, you will have the opportunity to object when you are able to do so. For example, if you have an appointment with us and you bring a family member with you and ask them to sit in treatment room with you during your examination or treatment, then we may disclose protected health information to that family member unless you object. Additionally, if you come to our office alone and Dr. Klein decides to admit you directly to the hospital, we may contact a family member or friend to let them know that you have been admitted to the hospital, unless you object.

**B. Uses and Disclosures Which Require Your Prior Written Authorization.** Uses and disclosures of your protected health information that are not listed above will be made only with your written authorization. If you sign an authorization to disclose your protected health information, you can later revoke that authorization in writing (except in very limited circumstances related to obtaining insurance coverage). If you revoke your authorization, will stop any future uses and disclosures except to the extent we have not already taken some action in reliance on your authorization).

**III. MORE STRINGENT PROTECTION FOR YOUR HEALTH INFORMATION**

In some cases, North Carolina law provides you with more stringent privacy protections of your health information than federal law, and where applicable, we will follow the requirements of those state laws. The following North Carolina laws may apply to our treatment of you:

- A.** North Carolina law protects not only your rights of privacy, but also your relationship with your physician. To allow us to disclose confidential information in your medical record under North Carolina law for treatment, payment, or health care operations, we will request that you sign a consent form (which differs from the authorization form mentioned in other parts of this Notice).



**East Carolina Dermatology and Skin Surgery, PLLC**

**Past History**

Patient Name:	Today's Date:
Current Age:	Birth Date:

**Please check illnesses or conditions you have had**

<input type="checkbox"/>	Abnormal bleeding	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Heart disease
<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Nervous disorder
<input type="checkbox"/>	Vein trouble	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Syphilis/Gonorrhea/Herpes	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Other		

<b>Date(s)</b>	<b>Serious injuries, broken bones, etc:</b>

<b>Date(s)</b>	<b>Previous operation(s), hospitalization(s)</b>

<b>Current Medications:</b>

<b>Medication Allergies:</b>

**Females Only**

Yes	No	Are you now pregnant?	Yes	No	Are you trying to get pregnant?
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Patient Name \_\_\_\_\_  
(Last) (First) (Middle) (Age)

Mailing Address \_\_\_\_\_  
(Street or PO Box Number) (City) (State) (Zip)

Home Phone(\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_) \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Full Time Student \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ Social Security # \_\_\_\_\_

**Parent, Spouse, or Responsible Party (if different from patient)**

Name \_\_\_\_\_  
(Last) (First) (Middle)

Mailing Address \_\_\_\_\_  
(Street or PO Box Number) (City) (State) (Zip)

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone(\_\_\_\_) \_\_\_\_\_ Cell Phone(\_\_\_\_) \_\_\_\_\_

Referred by \_\_\_Internet \_\_\_Phone Book \_\_\_Family/Friend \_\_\_Physician (Name) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number(\_\_\_\_) \_\_\_\_\_  
(Last) (First)

I hereby authorize release of information acquired in the course of my examination or treatment to those specific insurance carriers, third party payors or others involved in the processing and collection of my claims.

I hereby assign payment of any insurance benefits payable to me be made to East Carolina Dermatology. Patients who carry health insurance should remember that professional services are rendered and charged to the patient, not the insurance company. Insured patients are expected to take care of their fees as services are rendered. Even though an insurance claim is filed, you will receive a statement each month if your account has a balance due. The office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. Insurance claims not received in 60 days will be billed to the patient. I understand that I am responsible for the bill.

I give permission to East Carolina Dermatology & Skin Surgery to leave a message on my answering machine at home \_\_\_YES \_\_\_NO

Patient (or guardian if patient is under 18) Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_