

PANAMA CITY UROLOGICAL CENTER

80 Doctors Drive
Panama City, Florida 32405
Phone: (850) 785-8557
Fax: (850) 785-3497

Neal P. Dunn, M.D., F.A.C.S. Denis E. Healey, M.D., F.A.C.S. Jay C. Beiswanger, M.D. Carlos E. Ramos, M.D., F.A.C.S. J. Nicole Eisenbrown, M.D.
Michael A. Jenkins, M.D. Warren T. Hitt, M.D. James H. Wilkins, PA-C. James L. Cary, PA-C, M.H.A., Beatrice Soto, P.A.-C, M.A.

PATIENT DISCLOSURE FORM FOR HEALTH CARE INFORMATION

The Health Insurance Portability & Accountability Act of 1996 (S160.103)

Defines individual health information, including demographic information collected for an individual and:

1. Created or received by a health care provider, health plan, employer, or healthcare clearing house; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for provision of health care to an individual.
3. The information therefore identifies an individual or provides a reasonable basis to believe the information can be used to identify the individual.

Permitted disclosures (S164.502) and uses by a health care provider include:

1. For treatment, payment or health care operations as permitted under this law.
2. Uses or disclosure to a personal representative assigned by the patient.
3. Disclosure to the parents or persons acting *loco parentis* to an unemancipated minor.
4. For case management or care coordination for the individual or to direct or recommend alternative treatments, therapies, health care providers, health care settings.

Name of Patient: _____ **Date:** _____

Patient Social Security Number or Date of Birth: _____

I _____ am a patient of PANAMA CITY UROLOGICAL CENTER healthcare facility. I understand that I am required to inform the facility of the persons to whom they may disclose my medical information. These assigned persons may be changed at any time. This disclosure is effective April 14, 2003. This facility has provided me with a list of all the persons, agencies, or payers to whom my medical information may be disclosed during the course of any medical treatment by this facility.

I HAVE READ THE PERMITTED DISCLOSURE FORM AND ASSIGN THE FOLLOWING:

TRUSTEE: (Family member, lawyer, other who can access my medical information)

Name of Trustee: _____ Phone: _____

Address: _____

Name of Trustee: _____ Phone: _____

Address: _____

OVER

(Please make sure you sign the back of form)

HIPPA COMPLIANCE PLAIN BUSINESS ASSOCIATE LIST

The following list contains the business associates to whom we may disclose any form of personal health information on our patients. This is an ongoing list. This list will be included in the disclosure document released to the patients. These associates have a need to know or come in contact with patient information. The laboratories are included however are exempt under CLIA '88 for disclosure to anyone except the healthcare providers who order the tests.

The list and compliance become effective April 14, 2003

Associates: _____ Phone: _____

Address: _____

Associates: _____ Phone: _____

Address: _____

Associates: _____ Phone: _____

Address: _____

Associates: _____ Phone: _____

Address: _____

Associates: _____ Phone: _____

Address: _____

Associates: _____ Phone: _____

Address: _____

Associates: _____ Phone: _____

Address: _____

Patient Signature: _____ **Date:** _____