Resource Directory Liability Release Form

[Redacted] distributes a Community Resource Directory to assist patients in locating available services. Inclusion on this list does not indicate an endorsement from [Redacted] or warranty of their services. Representatives from these agencies act solely on behalf of themselves and are thereby wholly independent of [Redacted].

I [Redacted] understand and am fully aware that the [Redacted] provides a Resource Directory to assist patients and assumes no legal responsibility for services provided by other agencies.

I therefore agree to hold harmless and to release from liability [Redacted] Pregnancy Consultation Services, with respect to any and all claims or causes of action of any kind arising from or in any way related to any services offered or provided to me by any agency or organization on this list.

Patient Signature [Redacted] Date [Redacted]

[Redacted] Representative [Redacted] Date [Redacted]
HIPPA--NOTICE OF PRIVACY PRACTICES

I. This notice describes how medical information about you may be disclosed and how you can get access to this information. Please review it carefully.

Because we are a medical care provider that does not engage in any transactions that invoke coverage of the Health Information Insurance Portability and Accountability Act of 1996 (HIPAA), the privacy practices and terms described in this notice are voluntarily undertaken. Therefore, nothing in this notice should be construed as creating any contractual or legal right on behalf of patients. We reserve the right to modify our privacy practices and this notice at any time.

II. Safeguarding Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, or the provision of health care to you is considered "Protected health Information" (PHI). We will extend certain protections to your PHI. This notice explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we will only use or disclose the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

III. How We May Use and Disclose Your Protected Health Information

We use and disclose PHI for a variety of reasons. We may use and/or disclose your PHI for purposes of treatment or out health care operations. For uses beyond that, we will ordinarily obtain your written authorization. The following offers more description and some examples of the potential uses and disclosures of your PHI.

**Uses and Disclosures Relating to Treatment of Health Care Operation:** We may disclose your PHI to doctors, nurses and other health care personnel who are involved in providing health care. Your PHI may be shared with outside entities performing ancillary services to your treatment. Also, we may use and/or disclose your PHI as may be reasonably necessary in the course of operating our medical help clinic. We may also send or communicate appointment reminders, subject to our normal confidentiality policies and any special instructions that you have given.

**Uses and Disclosures for Which Special Authorization Will Be Sought:** For uses beyond treatment and operations purposes, we will ordinarily seek to obtain your authorization before disclosing for PHI. However, disclosure of your PHI may be made without your consent or authorization when required by law, when required for public health reasons, when necessary to avert a threat of harm to you or a third person, or when other circumstances may require or reasonably warrant such disclosure.

IV. How You May Have Access to or Control of Your Protected Health Information. The following is a description of the steps you may take to access or to otherwise control the disposing of your PHI:
To request restriction on uses/disclosures: You may ask that we limit how we use or disclose your PHI. We will consider your written request, but we are not legally bound to agree to the restriction. To the extent that we do agree to such restrictions, we will abide by such restrictions except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.

To choose how we contact you: You may ask that we send you information at an alternative address or by alternative means. We will accommodate reasonable requests that are in writing. We will not request an explanation from you as to the basis for the request.

To inspect and copy your PHI: Unless your access is restricted for clear and documented treatment reasons, you will be permitted to inspect your PHI upon written request. We will respond to your request within 30 days. If we deny your request for access, we will give you written reasons for the denial. If you request copies of your PHI, we will make reasonable efforts to accommodate any such request. You may designate selected portions of your PHI for copying. If you request copies, we will charge you $.25 for each page. If requesting that the information be mailed, there will also be a charge for postage.

To request amendment of your PHI: If you believe there is a mistake or missing information in our record of your PHI, you may request in writing that we correct or add to the record. You must provide us with a reason that supports your request for amendment. We will respond in 60 days upon receiving your written request. Any denial will state the reasons for the denial. We may deny your request if you ask us to amend information that is in our opinion

Accurate and complete
Not part of the PHI kept by or for the clinic
Not part of the PHI which you would be permitted to inspect and copy
Not created by our office, unless the individual or entity that created the information is not available to amend the information

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If we approve the request for amendment, we will change the PHI and so inform you. We will also inform any others who have a need to know about such changes.

To find out what disclosures have been made: You may request for us to provide you with a list of all disclosures of your PHI which we have made except for such disclosures as have been made in connection with your treatment, or health care operations, or as specifically required by law. We will respond to your written request within 60 days of receiving it.

To receive this notice: You may receive a paper copy of this notice upon request.

V. Contact Person: If you have any questions or concern about our privacy practices, please contact the Nurse Manager at [Contact Information]

VI. Acknowledgement: Please sign the accompanying document stating that you have read and if requested, received a copy of this notice.

Print Name [Redacted]
Signature [Redacted]
Date [Redacted]

Authorization to Release Information

Individuals / Medical Care Providers

Information given to private individuals will be limited to confirmation of appointment and/or obtaining material assistance. Medical Providers will receive reports upon request. I understand that confidentiality will be kept in all other instances except when Pregnancy Consultation Services is bound by law to report child abuse, suicidal, homicidal intentions or any type of abuse.

I authorize Pregnancy Consultation Services to give and receive information regarding my care from the following:

Please list authorized names

Spouse/Fiancé:  □ Yes  □ No
Parent:  □ Yes  □ No
Brother/Sister:  □ Yes  □ No
Son/Daughter:  □ Yes  □ No
Medical Care Provider:  □ Yes  □ No
Community Agencies  □ Yes  □ No
(Ex: Red Cross, Cribs for Kids, WIC, etc.)
Other:  □ Yes  □ No

I understand that this Authorization will expire in one year or specify date: 

I understand that I may revoke this Authorization at any time by notifying Pregnancy Consultation Services in writing, but if I do, it will not have any effect on any actions taken by Pregnancy Consultation Services prior to receiving the revocation. This authorization is voluntary and will not condition treatment on your signing this Authorization.

Patient’s Signature: ____________________________________________ Date: ____________

[Redacted] Representative ___________________________ Date: ____________

Date   Initials  Date   Initials  Date   Initials  Date   Initials  Date   Initials  Date   Initials
6/24/2010  

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