Patient Name: ______________________________ Patient Identifier #: __________________

Patient Preference Regarding Communication of Health Information

I. Who to Contact

I hereby give permission to ***Baylor Neurosurgery Associates*** to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or close personal friend(s):

Name	Relationship	Home Phone	Cell/Work Phone
Name	Relationship	Home Phone	Cell/Work Phone
Name	Relationship	Home Phone	Cell/Work Phone

☐ By checking this box, I do not wish to disclose any information with anyone.

II. How to Contact

I wish to be contacted in the following manner:

Home Phone:	Work Phone:
☐ OK to leave message with detailed information. ☐ Leave message with call-back number only.	☐ OK to leave message with detailed information. ☐ Leave message with call-back number only.

Written Communication

☐ OK to mail my home address: ______________________________
____
____

☐ OK to mail my work address: ______________________________
____
____

☐ OK to fax to this number: ______________________________

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

______________________________ ______________________________

Signature of Patient or Legal Representative Date

HEALTHTEXAS PROVIDER NETWORK
NOTICE OF HEALTH INFORMATION PRACTICES

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.

Understanding Your Health Record/ Information

This notice describes the practices of HealthTexas Provider Network (HTPN) and that of its physicians[1] with respect to your protected health information created while you are a patient at HTPN. HTPN physicians and personnel authorized to have access to your medical chart are subject to this notice. In addition, HTPN physicians may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at HTPN. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at HTPN.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of HTPN, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction;
- Obtain a paper copy of this notice of information practices;
- Inspect and request a copy of your health record as provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law;
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests; and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken in reliance on your authorization.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice, to the Compliance Officer at HealthTexas Provider Network, 8080 North Central Expressway, Suite 1700, LB 83, Dallas, TX, 75206.

Our Responsibilities

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures;
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you to request at HTPN. The revised notice will also be posted at HTPN offices and on the Baylor Health Care System web page at www.baylorhealth.edu.; and
- We will not use or disclose your health information without your written authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories.

We will use your health information for treatment.

For example: We may disclose medical information about you to

[1] *Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System, or Baylor Health Care System's subsidiary, community or affiliated medical centers.*

doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at HTPN. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays. We may also provide your physician or a subsequent health-care provider with copies of various reports to assist in treating you once you are discharged from care at HTPN.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health care operations.

For example: We may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We will use your health information as otherwise allowed by law. The following are some examples of how we may use or disclose medical information about you.

Business associates: There are some services provided in our organization through agreements with business associates. Examples include answering services and copy services. To protect your health information, however, we require business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to protect the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Communications for treatment and health care operations: 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: We may contact you as part of a fundraising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

Judicial, administrative and law enforcement purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative and law enforcement purposes.

Required or allowed by law: We will disclose medical information about you when required or allowed to do so by federal, state or local law.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Baylor Health Care System Office of HIPAA Compliance at 1-866-245-0815.

If you believe your privacy rights have been violated, you can file a complaint with the Baylor Health Care System Office of HIPAA Compliance or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EFFECTIVE DATE: 02/01/06
VERSION: 2

Patient Name:______________________________ Patient Identifier:__________________________

ACKNOWLEDGMENT OF THE RECEIPT OF HEALTHTEXAS PROVIDER NETWORK'S (HTPN) NOTICE OF HEALTH INFORMATION PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

HTPN is furnishing you with the attached notice, which provides information about how HTPN and its physicians[1] may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge that you have received a copy of HTPN's *Notice of Health Information Practices*.**

____ ____________________

(Signature of Patient or Legal Representative) **(Date)**

February 1, 2006
(Effective Date of *Notice*)

[1]Physicians are employees of HealthTexas Provider Network and are neither employees nor agents of Baylor Health Care System, or Baylor Health Care System's subsidiary, community or affiliated medical centers.

3600 Gaston Avenue, Suite 1158 Wadley Tower ⬢ Dallas, Texas 75246 ⬢ Phone 214-820-8585 ⬢ Fax 214-820-8590

Patient Name:____ Age: ______Date of Birth:____________

Chief Complaint: ____

HT:_______ WT:______ [] Right Handed [] Left handed

Referring /Primary Physician ____

Current Medications:

Medication Name	Dosage
____	____
____	____
____	____
____	____
________________________	________________________

Allergies to Medications:

____ ____
_____________________________________ _____________________________________

Past Medical History

Check all Medical conditions you have.

Y	N	Autoimmune Disorder	Y	N	Hepatitis C
Y	N	Blood Transfusion – Date___________	Y	N	Hypertension
Y	N	Colon Cancer	Y	N	Thyroid Disease
Y	N	Depression	Y	N	Liver Disease
Y	N	Diabetes Type 1	Y	N	Osteoarthritis
Y	N	Diabetes Type 2	Y	N	Stroke –CVA
Y	N	Blood Clots-DVT-Date_____________	Y	N	Seizure Disorder
Y	N	Hepatitis B	☐		Other_____________________________

Past Surgical History

Surgery	Date
____	____
____	____
____	____
____	____

Family Medical History

Family Member	**Alive/Deceased**	**Age**	**Health Status or Cause of Death**
Father______________________	______________		______________________________
Mother______________________	______________		______________________________
Siblings______________________	______________		______________________________
Paternal Grandmother__________	______________		______________________________
Paternal Grandfather___________	______________		______________________________
Maternal Grandmother__________	______________		______________________________
Maternal Grandfather___________	______________		______________________________

Social History: Check all that apply:

Marital Status ___Married __Single __Divorced ___Widowed

Children: _______Yes, How Many _____________ ___No

Smoker ____Yes How many Pack/Day_________ ___Former Quit/When ____ Never____

Alcohol _____Yes How much________________ ___No

Review of Systems:

Constitutional

Y N Chills
Y N Excessive fatigue
Y N Fever
Y N Weight loss

Cardiovascular/Respiratory

Y N Chest pain
Y N Chronic cough
Y N Difficulty breathing lying down (orthopnea)
Y N Palpitations
Y N Swelling in hands or feet (peripheral edema)
Y N Shortness of breath
Y N Fainting (Syncope)
Y N Wheezing

Genitourinary

Y N Painful urination (dysuria)
Y N Blood in urine (hematuria)
Y N Incontinence urinary
Y N Sexual dysfunction

Neuro/Psych

Y N Anxiety
Y N Balance problems
Y N Black outs
Y N Depression
Y N Frequent falls
Y N Frequent headaches
Y N Inability to concentrate
Y N Speech difficulty
Y N Walking difficulty
Y N Vertigo

EENT Ears Nose Throat

Y N Double vision (dipolpia)
Y N Drainage from ears
Y N Drainage from eyes
Y N Hearing loss
Y N Inability to smell
Y N Vision changes

Endo/Gastrointestinal

Y N Abdominal pain
Y N Bowel incontinence
Y N Difficulty swallowing (dysphagia)
Y N Heartburn/indigestion
Y N Yellow skin (jaundice)
Y N Nausea
Y N Painful swallowing (Odynophagia)
Y N Vomiting

Musculoskeletal

Y N Extremity pain
Y N Extremity weakness
Y N Joint pain
Y N Muscle weakness
Y N Poor range of motion
Y N Restless leg

Derm/Allergy

Y N Abnormal bruising
Y N Bleeding
Y N Rash
Y N Recurrent infections

The above information is accurate to the best of my knowledge.

____

Patient Signature **Date**

____

Physician Signature