Los Alamitos
CARDIOVASCULAR

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HIPAA PRIVACY REGULATIONS

Federal law, the Health Insurance Portability and Accountability Act of 1996, authorized the Department of Health and Human Services to adopt new rules to protect patient privacy.

Notification is therefore given that the office of LOS ALAMITOS CARDIOVASCULAR will not reveal personal information about you and/or your family member (i.e. name, address, social security number as well as other health information) without your permission. Your information will never be sold, or listed for the purpose of advertisement, solicitation or fund raising.

It is, however, understood that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the following context:

- Patient registration
- Procure medical records from former physicians
- Converse with colleagues for opinions/care
- Insurance: Verification, billing (paper, wire, digital), includes fax transmissions, insurance company/carriers, follow-up and interaction with billing services relating to patient care
- Hospital workers, nurses, aids and medical records departments
- Emergency officials, paramedics, fire personnel, emergency room physician, nurses and/or technicians and other support staff
- Personal religious designate
- Our office staff
- Pharmacists, drug program personnel/workers
- Review of external pharmacy history
- Completions of disability forms
- Computer and electronically stored information, i.e., related business vendors and service personnel

Additional Review Authorization

I authorize the following individual(s) (Family and/or Care Giver/Other) to receive and/or view my health care information maintained by Los Alamitos Cardiovascular:

Please print all information clearly:

Full Name: ______________________ Relationship: ______________

Street Address: ______________________ City: ______________, State ______ ZIP ________

Phone: (______) ______________ Mobile Phone: (______) ______________

Full Name: ______________________ Relationship: ______________

Street Address: ______________________ City: ______________, State ______ ZIP ________

Phone: (______) ______________ Mobile Phone: (______) ______________

My signature below authorizes the release of any necessary information listed above:

PATIENT SIGNATURE: ______________________ Date: ______________

GUARDIAN SIGNATURE: ______________________ Date: ______________

INSURED SIGNATURE: ______________________ Date: ______________

— A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL —

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