Parkinson's & Movement Disorders Center of Maryland
USE AND DISCLOSER OF PROTECTED HEALTH INFORMATION

Section I – Patient Acknowledgement & Consent Form

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Parkinson's and Movement Disorders Center of Maryland, LLC may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices states that we reserve the right to change terms described. Should this happen, we will display the new policy and effective date.

You have the right to request restrictions on how your protected health information may be used or disclose for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you.

By signing below, you acknowledge notification of Privacy Practices.

X	**X**
Patient/Guardian signature	*Date*
X	
Print Full Name	

Section II – Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, health care operations, and research. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or that you are being referred to for treatment.

Payment: We may use or disclose your health information to obtain payment for services we provide to you.

Record Access: Our entire staff is allowed full access to patient information in order to ensure the proper provision of treatment.

Research: We may use de-identified data for research purposes only. If you object, please inform your physician.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the healthy or safety of others.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, and/or letters).

X	**X**
Patient/Guardian signature	*Date*
X	
Print Full Name	

Continue...

Section III – Personal Representative or Family Authorized Access to Health Information

Name or specifically identify persons other than medical professionals you authorize disclosure to of your Protected Healthcare Information regarding treatment, payment, and other healthcare operations.

Name of Authorized Person or Entity	*Relationship*	*Phone Number*
Name of Authorized Person or Entity	*Relationship*	*Phone Number*
Name of Authorized Person or Entity	*Relationship*	*Phone Number*
Name of Authorized Person or Entity	*Relationship*	*Phone Number*

Section IV – Authorization for Use of Answering Machine/Voice Mail

PDMD Center physicians and staff are routinely unable to contact patients directly during normal business hours. On these occasions our office leaves messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule, we must obtain your authorization to continue this mode of communication. Protected Healthcare Information that we may possibly disclose on your home, work, or cell phone would include, but is not limited to: test/lab results, prescription/pharmacy information, and appointment confirmation and instructions.

x _____ (initial) Yes, I agree to allow PDMD Center of Maryland physicians and staff to leave messages that include Protected Healthcare Information on all three communication devices: home, work, and cell phone.

x _____ (initial) Yes, I agree to allow PDMD Center of Maryland physicians and staff to leave messages that include Protected Healthcare Information on the following devices: (Please initial next to the applicable communication device.)

_____ Home Phone _____ Work Phone _____ Cell Phone

x _____ (initial) No, I do not agree to allow PDMD Center of Maryland physicians and staff to leave messages that include Protected Healthcare Information on my home, work, and/or cell phone. (Confirmation calls will not be provided to patients that do not allow messages to be left.)

x _____ **x** _____

Patient/Guardian signature *Date*

x _____

Print Full Name

For Internal Office Use Only

☐ Consent received by _____ Date _____

☐ Consent refused by patient and treatment refused as permitted.