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

This notice of privacy practices describes how we may use or disclose your protected health information to carry out treatment for purposes that are permitted or required by law. It also describes your right to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this notice of privacy practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised notice of protected health information:

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we will disclose protected health information to other physicians who may be treating you when we have necessary permission from you to disclose your protected health information.

**Worker’s Compensation:** Your protected health information may be disclosed by use as authorized to comply laws and other similar legally established programs.

For questions or comments felt free to contact us at any time.
Authorization to Release Medical Records

I ______________________________ hereby authorize,

Occupational and Environmental Medicine of Houston
25722 Kingsland Blvd., Suite # 205

to disclose the following medical information by mail to:

Name____________________________________________________________

Street address _______________________________________________________________________

City, State, and Zip Code: __________________________________________

from the Health Records of:

Name: _____________________________________________________________

Street address: _____________________________________________________

City, State, and Zip Code: __________________________________________

My authorization extends only to those data elements/documents initialed below:

________ Records of visits (All visits)

________ Progress notes

________ Digital/other images

________ Discharge summary

________ History and physical examination

________ Consultation reports

________ All of the above

________ Other (Must be specific) ________________________________
Patient Consent and Acknowledgment or Receipt of Privacy Notice

I understand that as part of the provisions of healthcare services, Occupational and Environmental Medicine of Houston (OEMH) creates and maintains records and other information describing among other things, my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and Practices and prior to implementation will email a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restriction as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conduction or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosure have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without prior written authorization, except as otherwise provided by law.
2. A photocopy of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes or treatment, payment or healthcare operations, be restricted. I also understand that Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information, which have been previously agreed upon.

_______________________________________________

Patient's Name Printed

_______________________________________________

Patient's Signature

_______________________________________________

Date
This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time, except where information has already been released. This authorization is valid for one—year from the date it was signed, or sooner if noted below. The revocation to this authorization must be in writing.
4. Occupational & Environmental Medicine of Houston (OEMH) and its employees are authorized for disclosure of the above information to the extent indicated herein.
5. Treatment, payment, enrollment, or eligibility for benefits may not be conducted upon obtaining this Authorization.
6. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

__________________________________________________________
Patient’s Name (printed)

__________________________________________________________
Patient’s Signature (or guardian, if minor) Date