AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

1. I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed under this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations:

Patient Name _____ Date of Birth_____
Address_____ Telephone_____
_____ Patient No._____
Covering the period(s) of health care:
From (date)_____ To(date)_____, and

2. Information to be disclosed (check as many as appropriate):
___Complete health record(s), OR
ONLY:
__History & Physical Examinations ___Progress (Visit) Notes ___Billing/Financial
___Consultation Reports ___Laboratory Tests
___X-Ray Reports ___Photos, Tapes, X-Rays or Any Images

3. _____(Initials) I specifically consent to the release of any information related to testing and treatment for HIV, AIDS, mental health/psychiatric care, or alcohol and/or drug abuse if such is contained in the medical records. THIS PROVISION MUST BE INITIALED BY PERSON GIVING CONSENT OR THIS INFORMATION WILL NOT BE RELEASED.

4. This information is to be disclosed to (name & address) Information disclosed by (name & address)
_____ _____
_____ _____
_____ _____
for the purpose(s) of: _____, or.
❑ At the request of the patient

5. This authorization will expire on _____, not to exceed 1 year. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. If I fail to specify a date or otherwise revoke this authorization, this authorization will expire 1 year from the date signed below.

6. I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions: **1.** Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. **2.** Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

Signed: _____ _____
Patient Date
_____ _____
(OR) Legal Representative Date
_____ _____
Witness Date

Copy to be given to patient following signature. **Revised 3/18**

Authorization To Consent To Medical Treatment Of A Minor Child

It is best if the child is brought in for treatment by a parent or legal guardian. However; we know there are times when circumstances require a caregiver to bring a child to the office for medical treatment. We require the person who brings the child have consent from a parent or legal guardian in order for us to provide appropriate medical care.

Patient Name:	DOB:	SS#

Please list below the caregiver(s) that may need to bring your child to the office on your behalf:

Name	Address	Phone
1.		
2.		
3.		

I, _____ certify that I am the legal guardian of the child listed and have full authority to transfer my ability to make medical decisions to the caregiver(s) listed above in my absence.

- **This consent will remain in effect until it is revoked in writing.**
- **I am responsible to update this consent when any of the information in this document changes.**
- **I will be available at least by phone if the medical provider needs any information or to discuss treatment options.**
- **I will be financially responsible for all expenses that occur from the treatment of my child.**

Parent or Legal Guardian Name(Print): _____

Signature: _____ **Date:** _____

Contact number(s) Work: _____ **Cellphone:** _____

Witness Name(Print): _____

Witness Signature: _____ **Date:** _____

New Patient Information Sheet (more than 3 months old)

(Please complete all that applies based on your child's age)

Child's Name: _____ Date of Birth: _____

Child's Past Medical History:

Y/N Prior hospitalizations: _____

Y/N Prior Surgeries: _____

Y/N Current Medications: _____

Y/N Allergies _____

List any medical issues or chronic illnesses that your child has: (None)

Family History:

Please check if there is a family member with any of the following conditions and list relative:

( ) Asthma _____

( ) Heart Disease _____

( ) Heart Attack _____

( ) Diabetes _____

( ) Seizures _____

( ) Blood Disorder _____

( ) High blood pressure _____

( ) Mental illness _____

( ) Cancer _____

( ) Kidney disease _____

( ) Hearing loss _____

( ) Other diseases _____

( ) No known health problems in the family

Y/N Immunizations Up To Date Where were they done? _____

Y/N Do you consider your child's development as normal? _____

Y/N If in school, is your child progressing well academically? _____

Who lives in the home with this child? _____

Y/N Exposure to smoke in the home?

Y/N Well water?

Y/N Are there special circumstances about your family that we need to know?

Y/N Does your child have any unusual dietary habits? _____

Y/N Pets in the home _____

Y/N Any special communication needs? _____

Y/N Availability of resources to meet daily needs?

Parent work plans:

Mom _____

Dad _____

Childcare plans: _____

SUMMIT MEDICAL GROUP PATIENT REGISTRATION FORM

ACCOUNT #	DATE	PHYSICIANS NAME

PATIENT'S FIRST NAME	MIDDLE NAME	LAST	BIRTHDATE	AGE

ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY #	HOME PHONE #	MOBILE PHONE #	WORK OR BUSINESS PHONE #	MARITAL STATUS	SEX

EMPLOYER'S NAME AND ADDRESS	RACE	
		❑ 01 AFRICAN AMERICAN ❑ 08 NATIVE AMERICAN
		❑ 02 ASIAN ❑ 11 OTHER _____
		❑ 03 CAUCASIAN
		❑ 06 HISPANIC _____

EMAIL ADDRESS	PRIMARY LANGUAGE:

PHARMACY OF CHOICE	PHARMACY PHONE #

HOW WERE YOU REFERRED TO SUMMIT MEDICAL GROUP ?

HAVE YOU BEEN TREATED BY A SUMMIT MEDICAL GROUP PHYSICIAN PREVIOUSLY ? ☐ YES ☐ NO	DO YOU HAVE A DURABLE POWER OF ATTORNEY FOR HEALTHCARE ? ☐ YES ☐ NO DO YOU HAVE A LIVING WILL ? ☐ YES ☐ NO **If yes, Please provide a copy of the above document(s) to the office for your medical record.**

PERSON/GUARANTOR RESPONSIBLE FOR PAYMENT OF SERVICES (IF DIFFERENT FROM PATIENT)

FIRST NAME	MIDDLE NAME	LAST	RELATIONSHIP TO PATIENT

ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY #	HOME PHONE #	MOBILE PHONE #	WORK OR BUSINESS PHONE #	BIRTHDATE	SEX

EMPLOYER'S NAME AND ADDRESS

EMERGENCY CONTACT (NOT WITHIN THE SAME HOUSEHOLD)

NAME	EMERGENCY PHONE NUMBER	RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
INSURANCE NAME	EFFECTIVE DATE	INSURANCE NAME	EFFECTIVE DATE
CLAIMS ADDRESS		CLAIMS ADDRESS	
SUBSCRIBER ID NUMBER	GROUP NUMBER	SUBSCRIBER ID NUMBER	GROUP NUMBER
SUBSCRIBER NAME AND ADDRESS		SUBSCRIBER NAME AND ADDRESS	
SUBSCRIBER BIRTHDATE		SUBSCRIBER BIRTHDATE	
SUBSCRIBER SS#	RELATION TO PATIENT	SUBSCRIBER SS#	RELATION TO PATIENT
EMPLOYER NAME, ADDRESS AND PHONE NUMBER		EMPLOYER NAME, ADDRESS AND PHONE NUMBER	

FOR PRESCRIPTIONS, DO YOU USE YOUR ☐ PRIMARY INSURANCE ☐ SECONDARY INSURANCE ☐ OTHER

The Patient or Guarantor is responsible for payment in full of all services rendered by the physicians or employees of Summit Medical Group, PLLC. Payment in full is expected at the time of service unless arrangements are made in advance.

AUTHORIZATION, ASSIGNMENT, AND RESPONSIBILITY OF ACCOUNT

I hereby authorize Summit Medical Group, PLLC to release to the above insurance companies &/or carriers any medical or other information needed for claims reimbursement. I hereby assign, transfer, and set over to Summit Medical Group, PLLC all of my rights, title, and interest to medical reimbursement benefits under my insurance policy with the above documented insurance companies. I hereby acknowledge and accept responsibility for payment in full of all services rendered to me by Summit Medical Group, PLLC.

_____ _____

DATE *SIGNATURE OF PATIENT/GUARDIAN*

PATIENT CONSENT FOR MEDICAL TREATMENT

I, the undersigned, am the patient, or the patient's duly authorized representative, and do hereby voluntarily consent to and authorize medical care and treatment by Summit Medical Group, through its individual physicians, employees, and/or agents. This care and treatment encompasses all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician and provided by Summit Medical Group.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the physician or Summit Medical Group.

I acknowledge that I have received a copy of Summit Medical Group's Notice of Privacy Practices and I understand that the notice is also posted at each location where services are provided and on the internet at www.summitmedical.com. I consent to be called on my cell phone concerning healthcare services rendered to me.

To protect against the transmission of blood-borne diseases such as Hepatitis B and Acquired Immune Deficiency Syndrome, I understand that it may be necessary to test my blood for certain diseases while I am a patient of Summit Medical Group. I understand and consent that my blood, as well as the blood of any person accidentally exposed to my blood, will be tested. I further understand that my blood will not be tested for these diseases unless ordered by my physician and that the results of all tests will be kept confidential.

I have read this form, or had it read to me, and I certify that I fully understand and accept its contents unless noted.

_____ _____

Patient's Signature Patient's Name (Printed)

_____ _____

Witness Date

Patient, _____, is a minor, or is unable to sign above because: _____.
(Name Printed)

_____ _____

Person Giving Consent Relation to Patient

_____ _____

Witness Date

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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!

Summit Medical Group, PLLC ("Summit") is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes are:

- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Example of use of your health information for payment purposes:

- We submit requests for payment to your health insurance company. The health insurance company or business associate helping us obtain payment requests information from us regarding your medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

- We may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such business associates as necessary to obtain these services.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of Summit. You have the following rights with respect to your Protected Health Information

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office—we are not required to grant the request but we will comply with any request granted;
2. Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
3. Right to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request; appeal a denial of access to your protected health information except in certain circumstances;
4. Right to request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request. (The physician or other health care provider is not required to make such amendments); you may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
5. Right to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
6. Right to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we give you upon request; and,

If you want to exercise any of the above rights, please contact Summit's Privacy Officer in person or in writing, during normal hours. They will provide you with assistance on the steps to take to exercise your rights.

Summit's Responsibilities

Summit is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request;
- Accommodate your reasonable requests regarding methods to communicate health information with you;
- Accommodate your request for an accounting of disclosures; and
- Notify you in the event there is a breach of unsecured protected health information.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact:

Privacy Officer
1225 E. Weisgarber Road, Suite N-200
Knoxville, TN 37909
(865) 584-4747
ComplianceHelp@summithealthcare.com

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the Privacy Officer. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.

We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Effective Date: *April 14, 2003*
Revised Date: May 1, 2013

FOLLOWING IS A LIST OF OTHER USES AND DISCLOSURES ALLOWED BY THE PRIVACY RULE

Patient Contact

We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. We may contact you as part of a fund raising effort.

Notification – Opportunity to Agree or Object

Unless you object we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family - Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

We may use and disclose your protected health information to assist in disaster relief efforts.

Opportunity to Agree or Object Not Required

PUBLIC HEALTH ACTIVITIES

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

Child Abuse & Neglect - We may disclose protected health information to public authorities as allowed by law to report child abuse or neglect.

Food and Drug Administration (FDA) - We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Employment Related – We may disclose to employers your protected health information to the extent such information is related to medical surveillance or evaluation of a work related injury or illness if the employer needs such information to comply with OSHA rules and regulations.

VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE

We can disclose protected health information to governmental authorities to the extent the disclosure is authorized by statute or regulation and in the exercise of professional judgment the doctor believes the disclosure is necessary to prevent serious harm to the individual or other potential victim.

OVERSIGHT AGENCIES

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities to include audits, civil, administrative or criminal investigations: inspections; licensures or disciplinary actions, and for similar reasons related to the administration of healthcare.

JUDICIAL/ADMINISTRATIVE PROCEEDINGS

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order or administrative tribunal, provided that only the protected health information released is expressly authorized by such order, or in response to a subpoena, discovery request or other lawful process.

LAW ENFORCEMENT

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by court order, including laws that require reporting of certain types of wounds or other physical injury.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS

We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

ORGAN PROCUREMENT ORGANIZATIONS

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

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 ensure the privacy of your protected health information.

THREAT TO HEALTH AND SAFETY

To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

FOR SPECIALIZED GOVERNMENTAL FUNCTIONS

We may disclose your protected health information for specialized government functions as authorized by law such as to armed forces personnel, for national security purposes, or to public assistance program personnel.

CORRECTIONAL INSTITUTIONS

If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

WORKERS COMPENSATION

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to workers compensation.

Other Uses and Disclosures

- Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization which you may revoke except to the extent information or action has already been taken.

Website

- This Notice is also located on our website. Please go to www.summitmedical.com.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

- **Psychotherapy notes-** authorization must be obtained for any use or disclosure of psychotherapy notes except to carry out Treatment, Payment, or Operations or to defend ourselves in a legal action brought by the subject of the notes.
- **Marketing-** authorization must be obtained except if the communication is in the form of a face-to-face communication or in the form of a promotional gift by your healthcare provider.
- **Sale-** authorization must be obtained prior to any disclosure for the sale of protected health information.