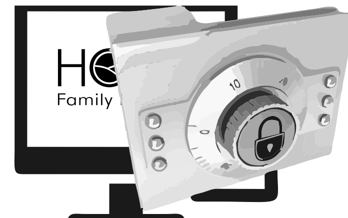
PATIENT LAST NAME ______	PATIENT FIRST NAME ______	PATIENT DATE OF BIRTH ______

HI001

acknowledgment of health center privacy policy, privacy practices, and privacy procedures

PATIENT PRIVACY



! *HOPE's Statement of Privacy Practices can be found at any health center reception desk or on our website at www.HOPEfamilyhealth.org/privacy*

HOPE IS COMMITTED TO THE PRIVACY & SECURITY OF PATIENT INFORMATION

POLICY: HI001 | HIPAA & Privacy Policy | EQUALLY APPLICABLE TO BOTH MEDICAL AND BEHAVIORAL HEALTH RECORDS, VISITS & TREATMENTS
It is the policy of HOPE Family Health to adopt and implement legally sound and fully compliant (with both federal and state laws) procedures by which to govern the access, use, disclosure, dissemination, storage, and sharing of our patient's protected health information and medical and behavioral healthcare records in an integrated medical/primary and behavioral healthcare environment. The board appointed Chief Compliance Officer shall also serve as the health center's Privacy Officer, whose responsibility is to ensure that minimum necessary disclosure is occurring at all times when HFH employees, contractors, and/or agents are interacting with Protected Health Information. It is also the responsibility of the Privacy Officer to thoroughly investigate any instances of breach of privacy or any reports thereof. PROCEDURE FOR: HI001 | The procedure for this policy is located within the procedures for related Policy HI003 – Statement of Privacy & Health Information Practices & Procedures.

POLICY: HI002 | Health Record Policy | EQUALLY APPLICABLE TO BOTH MEDICAL AND BEHAVIORAL HEALTH RECORDS, VISITS & TREATMENTS
It is the policy of HOPE Family Health to establish, maintain and protect a health record on each and every patient that receives care from a HFH medical or behavioral health provider. This record shall comply with all other policies and procedures of HOPE Family Health, as well as federal and state laws and regulations. Creation, destruction, storage, access to and maintenance of this record shall also remain compliant with all federal and state laws, as well as all other health center policy. PROCEDURE FOR: HI002 | The procedure for this policy is located within the procedures for related Policy HI003 – Statement of Privacy & Health Information Practices & Procedures.

POLICY: HI003 | Statement of Privacy & Health Information Practices & Procedures | EQUALLY APPLICABLE TO BOTH MEDICAL AND BEHAVIORAL HEALTH RECORDS, VISITS & TREATMENTS
This Statement of Privacy and Health Record Practices and Procedures comply with all federal HIPAA laws as well as the laws and regulations of the State of Tennessee that govern patient privacy and healthcare information disclosures in an integrated medical/primary and behavioral healthcare environment. This Statement of Privacy Practices should be made available to every patient and HFH shall make every reasonable attempt to address any questions or concerns any patient has regarding HFH's Privacy Practices or Procedures. Privacy Practices and Procedures should be updated when changes are made to federal and state laws that govern such practices. PROCEDURE FOR: HI003 | This statement describes how medical information about you as the patient may be used and disclosed and how you can get access to this information. This includes information about you that is both contained within your health record as well as information about you that may not be contained within your health record. Please review it carefully, and in full, and understand that by signing the acknowledgment (Form HI001) contained in this document, you are agreeing to give HOPE Family Health permission to operate using these practices. A copy of this document can be found online at www.HOPEfamilyhealth.org/privacy

SECTION 1 | HFH has a Commitment to Patient Privacy | EQUALLY APPLICABLE TO BOTH MEDICAL AND BEHAVIORAL HEALTH RECORDS, VISITS & TREATMENTS
HOPE Family Health (called HFH hereafter in this statement) is careful to protect the privacy of our patients' medical information. We respect your right to privacy and we comply with all federal and state laws that have been passed to insure your privacy. We handle your personal health information with the utmost care. We hope that this statement of our privacy practices answers any questions or concerns that you might have about the privacy of your personal health information. Please ask any member of our team to speak to HOPE's Privacy Officer if there is anything you do not understand or wish to know more about.

SECTION 2 | HFH is Mandated by Law to Protect Patient Privacy | EQUALLY APPLICABLE TO BOTH MEDICAL AND BEHAVIORAL HEALTH RECORDS, VISITS & TREATMENTS
HFH is required, as are all healthcare providers, by federal and state law to maintain the privacy of protected health information. We are also required by law to give you this statement and to operate by the practices as declared in this statement. These laws require us to give you this notice in advance of your first service whenever possible. Laws and regulations also allow us to collect information via phone or other means ahead of time to expedite (speed up) our service to you and allow us to treat you immediately in an emergency as long as we make a good faith effort to present you with the statement as soon as possible. ,. These laws go one step further and require that you as our patient sign this statement, acknowledging you have read and understand what it says. We are also required by law to prominently post this notice and any future revisions in all of our places of service. If you do not see this notice posted, please ask any staff person to point it out to you. We can also give you a new copy at any time you may need.

SECTION 3 | Statement Effective Date, Revisions, and Previous Versions | EQUALLY APPLICABLE TO BOTH MEDICAL AND BEHAVIORAL HEALTH RECORDS, VISITS & TREATMENTS
This edition of this statement is effective as of May 1, 2015, however an earlier version was originally effective on January 1, 2005. We may in the future find that it is necessary to change our practices, and/or update our privacy procedures, and reserve the right to do so without notice. Any change to our practices will be highlighted and dated on the posted statement of our practices at all of our service locations by the time any changes go into effect and we will begin distributing revised statements by the date that any changes take effect. You can always find the date when new practices went into effect at the top of any copy of this statement and our practices. We encourage you to check our posted practices each time you visit, or whenever you may have a question about your privacy as a patient. If we do find it necessary to change our practices over time we will not segregate (set apart or separate) our records according to the notice in effect at the time the entries into the records were created. We specifically reserve the right to not segregate our records in this notice. You are entitled to a copy of our privacy practices and any revisions at any time so please ask any staff person or ask to speak to the Privacy Officer if you ever have any questions or needs related to your privacy. ------------------------------

SECTION 4 | Patient Acknowledges Awareness and Understanding of this Statement | EQUALLY APPLICABLE TO BOTH MEDICAL AND BEHAVIORAL HEALTH RECORDS, VISITS & TREATMENTS
APPLICABLE FORM: HI001 -Acknowledgment of Health Center Privacy Policy, Privacy Practices, and Privacy Procedures
The law further requires that we must make a good faith effort to obtain your written acknowledgment of receipt of this notice. That is why we are asking you (or your personal representative, for example, a parent of a child) to sign form HI001 "Acknowledgment of Health Center Privacy Policy, Privacy Practices, and Privacy Procedures" saying that we have given you this notice. If you refuse or otherwise do not sign this acknowledgment, the staff person who presented it to you will sign a statement saying that they gave it to you for our records. The fact that you do not sign, does not change our practices, procedures, or our commitment to maintaining the privacy of your protected health information. If you have questions at any time about this statement or anything in it, please ask a member of the HOPE staff . If they do not answer your questions or address your concerns to your satisfaction please call the health center's Privacy Officer, Joey Forman, CIO, CCO at (615) 644-2000 and use extension 473. Or you can email the Privacy Officer at joeyforman@hopefamilyhealth.org

______________________________ ______________

PATIENT OR GUARDIAN SIGNATURE DATE

PATIENT LAST NAME ____________	PATIENT FIRST NAME ____________	PATIENT DATE OF BIRTH ____________

HI002a

authorization for the disclosure of health information

MEDICAL HEALTH

I AUTHORIZE HOPE TO COMMUNICATE WITH ME ABOUT MY MEDICAL HEALTH

BY SIGNING BELOW I AGREE TO ALLOW HOPE FAMILY HEALTH TO COMMUNICATE WITH ME IN PERSON, PHONE, VOICE MESSAGE, EMAIL, DIRECT MAIL AND/OR TEXT MESSAGE WHENEVER AND USING WHICHEVER METHOD IS APPLICABLE, APPROPRIATE AND AVAILABLE.

I UNDERSTAND THAT IF I WISH FOR HOPE TO COMMUNICATE WITH ME IN A SPECIFIC WAY OR WISH FOR HOPE TO NOT COMMUNICATE WITH ME USING A SPECIFIC METHOD, I MUST COMPLETE FORM Hi002a5: *"Patient Request for Privacy Through Alternative Communication"*

PATIENT OR GUARDIAN SIGNATURE ____________ DATE ____________

I AUTHORIZE HOPE TO COMMUNICATE WITH MY LOVED ONES ABOUT MY MEDICAL HEALTH

BY SIGNING BELOW I AUTHORIZE HOPE FAMILY HEALTH TO DISCUSS MY MEDICAL HEALTH CARE, MEDICAL HEALTH HISTORY, DIAGNOSIS INFORMATION & TREATMENT OPTIONS WITH THE FOLLOWING INDIVIDUALS:

PATIENT OR GUARDIAN SIGNATURE ____________ DATE ____________

HOPE Family Health

PATIENT LAST NAME ____________________ PATIENT FIRST NAME ____________________ PATIENT DATE OF BIRTH ____________

authorization for the disclosure of health information

MEDICAL HEALTH

HOPE MAY RELEASE / SEND MY MEDICAL HEALTH INFORMATION TO:

I hereby authorize HOPE Family Health and its physicians, mid-level providers, employees, and agents to release or disclose my protected health information including medical health records pertaining to treatment, prognosis, and diagnosis, including any specially protected or listed records such as those pertaining to HIV and AIDS or any other communicable diseases, drug abuse, alcoholism, or any other condition or diagnosis. LIST BELOW ANY/ALL HEALTH CARE PROVIDERS/ATTORNEYS/REHAB FACILITIES, SPECIALISTS, ETC. THAT YOU WISH FOR HOPE FAMILY HEALTH TO RELEASE YOUR MEDICAL HEALTH INFORMATION TO:

____________________ FOR HFH OFFICE USE ONLY

____________________ FOR HFH OFFICE USE ONLY

THE REASON FOR THIS AUTHORIZED DISCLOSURE AND DESCRIPTION OF RECORDS TO BE RELEASED:

HOPE MAY REQUEST / ORDER MY MEDICAL HEALTH INFORMATION FROM:

I authorize and request the disclosure of all protected information to HOPE Family Health for the purpose of review and evaluation as it pertains to my health and medical diagnosis, prevention and treatment. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following: (please check all that you wish to release) All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, inpatient, outpatient and emergency room treatment, all clinical charts, report order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment correspondence, photographs, videotapes, telephone messages, and records received by other medical providers. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

- All physical, occupational and rehabilitation requests, consultations and progress notes.
- All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
- All employment, personnel or wage records.
- All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including
- CT scan, MRI, MRA, EMG, bone scan, myleogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human of this type of information. This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived. I understand the following: See CFR §164.508(c)(2)(i-iii) A. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. B. The information released in response to this authorization may be re-disclosed to other parties. C. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. LIST BELOW ANY/ALL HEALTH CARE PROVIDERS, PHYSICIANS, REHAB FACILITIES, SPECIALISTS, OFFICES, HOSPITALS, TREATMENT CENTERS OR OTHER MEDICAL FACILITIES YOU HAVE VISITED IN THE PAST 5 YEARS THAT YOU WISH FOR HOPE FAMILY HEALTH TO REQUEST YOUR MEDICAL HEALTH INFORMATION FROM:

____________________ FOR HFH OFFICE USE ONLY

____________________ FOR HFH OFFICE USE ONLY

THE REASON FOR THIS AUTHORIZED DISCLOSURE AND DESCRIPTION OF RECORDS TO BE RELEASED:

PATIENT OR GUARDIAN SIGNATURE ____________________ DATE ____________

SECURELY FAX RELEASES TO: 615-644-2078

1124 New Hwy 52 E, Westmoreland, TN, 37186 | p: 615-644-2000 | f: 615-644-2078 | email: info@hopefamilyhealth.org

PLEASE RELEASE RECORDS TO HFH USING SECURE EMAIL OR FAX AS THE PREFERRED METHOD

PATIENT LAST NAME	PATIENT FIRST NAME	PATIENT DATE OF BIRTH

HI003a

authorization for the disclosure of health information

BEHAVIORAL HEALTH

I AUTHORIZE HOPE TO COMMUNICATE WITH ME ABOUT MY BEHAVIORAL HEALTH

BY SIGNING BELOW I AGREE TO ALLOW HOPE FAMILY HEALTH TO COMMUNICATE WITH ME IN PERSON, PHONE, VOICE MESSAGE, EMAIL, DIRECT MAIL AND/OR TEXT MESSAGE WHENEVER AND USING WHICHEVER METHOD IS APPLICABLE, APPROPRIATE AND AVAILABLE.

I UNDERSTAND THAT IF I WISH FOR HOPE TO COMMUNICATE WITH ME IN A SPECIFIC WAY OR WISH FOR HOPE TO NOT COMMUNICATE WITH ME USING A SPECIFIC METHOD, I MUST COMPLETE FORM Hi002a5: *"Patient Request for Privacy Through Alternative Communication"*

PATIENT OR GUARDIAN SIGNATURE ______________________ DATE ____________

I AUTHORIZE HOPE TO COMMUNICATE WITH MY LOVED ONES ABOUT MY BEHAVIORAL HEALTH

BY SIGNING BELOW I AUTHORIZE HOPE FAMILY HEALTH TO DISCUSS MY BEHAVIORAL CARE, MENTAL HEALTH HISTORY, DIAGNOSIS INFORMATION & TREATMENT OPTIONS WITH THE FOLLOWING INDIVIDUALS:

PATIENT OR GUARDIAN SIGNATURE ______________________ DATE ____________

HOPE
Family Health

PATIENT LAST NAME ______	PATIENT FIRST NAME ______	PATIENT DATE OF BIRTH ______

HI003b

A NEW AUTHORIZATION MUST BE COMPLETED FOR EACH BEHAVIORAL HEALTH DISCLOSURE

authorization for the disclosure of health information

BEHAVIORAL HEALTH

I AUTHORIZE THE RELEASE OF MY BEHAVIORAL HEALTH RECORDS...

Purpose and Laws: This form, when properly completed, permits the release of confidential information about a person receiving services (service recipient) governed and regulated by Title 33, Tennessee Code Annotated. Any information to be released under this form shall be released in accordance with the following confidentiality laws and regulations: Title 33, Tennessee Code Annotated; the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its regulations at 45 Code of Federal Regulations (CFR) Parts 160 and 164; and the federal Confidentiality of Alcohol and Substance Abuse Patient Records and its regulations at 42 CFR Part 2. The records released through this Authorization are protected by the above named confidentiality laws and regulations. A general authorization for the release of medical or other information is NOT sufficient for the purpose of disclosing mental health or alcohol and substance abuse information. Federal rules restrict any use of alcohol and substance abuse information to criminally investigate or prosecute the person to whom the information pertains. Further disclosure of this information to parties other than those designated on this form is expressly prohibited without the express written consent of the person to whom the information pertains.By signing below I authorize HOPE Family Health to disclose to disclose my behavioral health records and behavioral health information (not including any psychotherapy and/or counseling notes (as by law, this kind of information requires the use of a separate form Hi002a2b). I authorize the release and disclosure of all other behavioral health records from any and all exam/treatment/session dates deemed necessary for this disclosure. If there is any specific behavioral health information and/or records I do not wish to be disclosed, that information is listed below.

THE REASON FOR THIS AUTHORIZED DISCLOSURE AND DESCRIPTION OF RECORDS TO BE RELEASED:

PHONE:

FAX:

EMAIL:

MAIL:

I (printed name at the top of this form) AUTHORIZE HOPE FAMILY HEALTH TO...

☐ REQUEST ALL BEHAVIORAL HEALTH RECORDS ON FILE FROM.................

☐ SEND ALL BEHAVIORAL HEALTH RECORDS ON FILE TO............................

☐ THIS AUTHORIZATION SHOULD INCLUDE ALL BEHAVIORAL HEALTH RECORDS EXCEPT (BUT NOT) THOSE PERTAINING TO (details):

☐ THIS AUTHORIZATION SHOULD ONLY INCLUDE BEHAVIORAL HEALTH RECORDS PERTAINING TO (details):

By signing this form, I (the service recipient) understand that if the person or organization designated on this form to receive the information is not a Health Plan or Health Care Provider, some of the released information may no longer be protected by the above named confidentiality laws and regulations. I also understand that signing this Authorization is voluntary, and that I am not required to sign this Authorization in order to get treatment, payment, enrollment, or eligibility for benefits. I also understand that I may revoke this Authorization by doing so in writing at any time; except to the extent that action has been taken in reliance on the information, and that the revocation does not affect any information that was released before the revocation. Even if I do not revoke this Authorization, the Authorization expires automatically one (1) year from the date of signature. If I want it to expire before then, I will indicate the date of which I request as the following: DESIRED EXPIRATION DATE:

PATIENT OR GUARDIAN SIGNATURE (guardian if patient is 15 y/o or younger) DATE

If a patient gives oral consent or signs with an X, this form must be signed by two (2) witnesses:

*** If the individual signing this form is acting on behalf of the service recipient, the individual is: (1) the parent, legal guardian, or legal custodian of a service recipient who is under 18 years of age; (2) the conservator or guardian for the service recipient; (3) the guardian ad litem of the service recipient but only for the purposes of the litigation in which the guardian ad litem serves; (4) the attorney-in-fact under a power of attorney who has the right to make disclosures under the power for the service recipient; (5) the executor, administrator, or personal representative on behalf of a deceased service recipient; and (6) the treatment review committee, acting within the authority and scope of Tennessee Code Annotated Section 33-6-107. Appropriate documentation of proof of this individual's authority to act on behalf of the service recipient must be submitted to the entity being asked to release the information before any information will be released.*

WITNESS 1 SIGNATURE & DATE

WITNESS 1 SIGNATURE & DATE

SECURELY FAX RELEASES TO: 615-644-2078

1124 New Hwy 52 E, Westmoreland, TN, 37186 | p: 615-644-2000 | f: 615-644-2078 | email: info@hopefamilyhealth.org

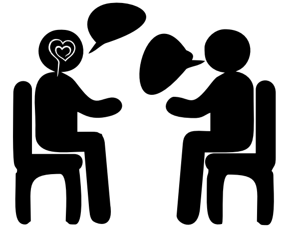
PLEASE RELEASE RECORDS TO HFH USING SECURE EMAIL OR FAX AS THE PREFERRED METHOD

PATIENT LAST NAME ______	PATIENT FIRST NAME ______	PATIENT DATE OF BIRTH ______

COURT ORDER OR PSYCH. PROVIDER AUTHORIZATION REQUIRED PRIOR TO THIS RELEASE

authorization for the disclosure of health information

PSYCHOTHERAPY



I AUTHORIZE THE RELEASE OF MY PSYCHOTHERAPY/COUNSELING NOTES

I hereby authorize HOPE Family Health to release the information contained in my Psychotherapy / Counseling Notes to the Recipient(s) named on this form. Psychotherapy / Counseling Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical and/or behavioral health record. By signing below I authorize HOPE Family Health to disclose to disclose my Psychotherapy / Counseling Notes (as by law, this kind of information requires the use of a separate form Hi002a2b). I authorize the release and disclosure of all notes from any and all session dates deemed necessary for this disclosure. If there are any specific Counseling / Psychotherapy notes and/or records I do not wish to be disclosed, that information is listed as the following:

THE REASON FOR THIS AUTHORIZED DISCLOSURE AND DESCRIPTION OF RECORDS TO BE RELEASED:

PHONE:

FAX:

EMAIL:

MAIL:

I (printed name at the top of this form) AUTHORIZE HOPE FAMILY HEALTH TO...

- ☐ REQUEST ALL PSYCHOTHERAPY/COUNSELING NOTES ON FILE FROM...
- ☐ SEND ALL PSYCHOTHERAPY/COUNSELING NOTES ON FILE TO.............
- ☐ THIS AUTHORIZATION SHOULD INCLUDE ALL BEHAVIORAL HEALTH RECORDS EXCEPT (BUT NOT) THOSE PERTAINING TO (details):
- ☐ THIS AUTHORIZATION SHOULD ONLY INCLUDE BEHAVIORAL HEALTH RECORDS PERTAINING TO (details):

By signing this form, I (the service recipient) understand that if the person or organization designated on this form to receive the information is not a Health Plan or Health Care Provider, some of the released information may no longer be protected by the above named confidentiality laws and regulations. I also understand that signing this Authorization is voluntary, and that I am not required to sign this Authorization in order to get treatment, payment, enrollment, or eligibility for benefits. I also understand that I may revoke this Authorization by doing so in writing at any time; except to the extent that action has been taken in reliance on the information, and that the revocation does not affect any information that was released before the revocation. Even if I do not revoke this Authorization, the Authorization expires automatically one (1) year from the date of signature. If I want it to expire before then, I will indicate the date of which I request as the following: DESIRED EXPIRATION DATE:

PATIENT OR GUARDIAN SIGNATURE (guardian if patient is 15 y/o or younger) ______ DATE ______

**If a patient gives oral consent or signs with an X, this form must be signed by two (2) witnesses:*

*** If the individual signing this form is acting on behalf of the service recipient, the individual is: (1) the parent, legal guardian, or legal custodian of a service recipient who is under 18 years of age; (2) the conservator or guardian for the service recipient; (3) the guardian ad litem of the service recipient but only for the purposes of the litigation in which the guardian ad litem serves; (4) the attorney-in-fact under a power of attorney who has the right to make disclosures under the power for the service recipient; (5) the executor, administrator, or personal representative on behalf of a deceased service recipient; and (6) the treatment review committee, acting within the authority and scope of Tennessee Code Annotated Section 33-6-107. Appropriate documentation of proof of this individual's authority to act on behalf of the service recipient must be submitted to the entity being asked to release the information before any information will be released.*

WITNESS 1 SIGNATURE & DATE ______ *WITNESS 1 SIGNATURE & DATE* ______

HOPE Family Health

SECURELY FAX RELEASES TO: 615-644-2078

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PLEASE RELEASE RECORDS TO HFH USING SECURE EMAIL OR FAX AS THE PREFERRED METHOD

PATIENT LAST NAME	PATIENT FIRST NAME	PATIENT DATE OF BIRTH

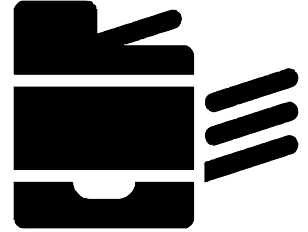
HI006

SUBMIT A COPY OF THIS FORM TO HFH AR/AP AFTER RELEASE IS COMPLETE

THIS FORM IS TO BE USED BY HFH AS A FEE STATEMENT FOR THIS SERVICE

authorization for the disclosure of health information

DISCLOSURE COST



THE COST OF RELEASING & DISCLOSING HEALTH RECORDS & INFORMATION

The release of patient health information is governed under federal and state laws. To release medical or behavioral health records and other health information, the patient or entity making the request must follow HOPE Family Health's procedure that has been developed to both protect confidential information, as well as to assist in making sure all applicable laws are followed. To release health information from HOPE Family Health, the requestor must complete all sections of form(s): (check which type of release(s) being requested:

- ☐ Hi002b *"Authorization for the disclosure of Medical Health Information"* (for medical records)
- ☐ Hi003b *"Authorization for the disclosure of Behavioral Health Information"* (for behavioral records).

Requests must then hand-delivered, mailed, emailed or faxed to HFH using the information at the bottom of the request. If under the age of 18, a parent or legal guardian must sign as well. HFH reserves the right to accept a release for health information that has been completed on the form of a different provider or health care entity, so long as HFH verifies the forms legitimacy and that it includes all of the information required by state and federal law. For any other type of request, HFH requires that the forms listed above be used.

☐ REQUESTS MADE BY THE PATIENT FOR PERSONAL USE OR A THIRD PARTY NOT INVOLVED IN THE PATIENT'S IMMEDIATE CARE

If a patient (for personal use) OR a third party that is not involved in the patient's immediate care (such as an attorney) is making the request - after completing the form(s) listed above, the requestor must agree to pay the associated fees as established by federal and state law and based on TN Code Annotated 63-2-102 & 68-11-304 and HIPAA 45 CFR 164.524. The first 5 pages will cost $20.00 and each additional page will cost $0.50 - which includes only the cost of copying, supplies and labor. In addition to the charge per page, the actual cost of postage will also be added, if the patient requests that the copy be mailed. If the entity making the request has already established a fee structure for these costs, HFH may elect to charge based on what has already been established. This release will include the health information that is relevant to your immediate care. **This is called an abstract**.

☐ REQUESTS MADE BY OTHER HEALTH CARE PROVIDERS INVOLVED IN THE PATIENT'S IMMEDIATE CARE

At no cost to the patient or provider, we will provide another health care provider that is directly involved in the patient's immediate care with the health information that is relevant to that immediate care. **This is called an abstract**. If the provider accepts this disclosure via electronic transmission or by secure facsimile - HFH does not regularly charge a fee for this disclosure, however is permitted to by law, so this courtesy can be revoked at any time (and without prior notice) at the discretion of HFH staff.

WHAT IS THE DIFFERENCE IN AN ABSTRACT RELEASE VS. THE COMPLETE LEGAL HEALTH RECORD?

An abstract contains only the health records needed by the patient and providers to assist in or to continue your immediate care. This is what is released unless a legal health record is requested. The contents of the abstract release are determined by your care team here at HOPE and usually include(s): Discharge and/or Visit Summary, History of Presenting Illness & Physical, Labs, Pathology Report(s), Operative Report(s), Procedure Notes, Radiology Report(s), Problem List and Medications. In addition to what is in the abstract, your legal health record has all the information needed to identify you, support your diagnosis, justify your treatment, and document your care and results. HFH's Privacy Officer must approve this type of disclosure.

DESCRIPTION OF CHARGE	# OF PAGES	RATE	AMOUNT
First 5 pages	5	$20.00	$20.00
Health Information Pages after the first 5		X $0.50 per page	
Actual Cost of Postage (if none use $0.00)	-----------		
TOTAL COST OF DISCLOSURE:	☐ REQUESTOR'S FEE STRUCTURE IS BEING USED INDICATE & CALCULATE COST HERE:		

HOPE REPRESENTATIVE WHO PREPARED THIS DISCLOSURE ______________ DATE ______________

PLEASE REMIT PAYMENT FOR THE COST OF THIS DISCLOSURE TO HFH WITHIN 15 BUSINESS DAYS OF RECEIVING IT

1124 New Hwy 52 E, Westmoreland, TN, 37186 | p: 615-644-2000 | f: 615-644-2078 | email: info@hopefamilyhealth.org

PATIENT LAST NAME ____________	PATIENT FIRST NAME ____________	PATIENT DATE OF BIRTH ____________

HI005

patient request for privacy through alternative means of communication or alternative location

COMMUNICATION

HOPE RESPECTS YOUR RIGHT TO PRIVACY AND YOUR SPECIAL REQUEST

I hereby request as of the date I sign this form, an alternative means of communication of my health information as a patient at HOPE Family Health (example: regular mail, specific telephone number, facsimile, email, text, voice messages, etc.) or communication of my health information to an alternate location. I understand that request for communication by alternative means or to an alternate location is applicable only to information held by HOPE Family Health (HFH) and disclosure by alternative means may not be protected and could endanger me. I understand that this request may cause communication to be intercepted by others and HFH is not responsible if such intercepts occur. I also understand that if such a restriction or request for alternative communication conflicts with HFH's ability to communicate with the appropriate payor, that I am responsible for any associated fees that may occur.

PLEASE NEVER SEND ME MAIL TO THIS ADDRESS:
☐medical ☐behavioral ☐both

PLEASE ONLY SEND ME MAIL TO THIS ADDRESS:
☐medical ☐behavioral ☐both

PLEASE NEVER CALL ME AT THIS PHONE NUMBER:
☐medical ☐behavioral ☐both

PLEASE ONLY CALL ME AT THIS PHONE NUMBER:
☐medical ☐behavioral ☐both

NEVER LEAVE ME A MESSAGE AT THIS PHONE NUMBER:
☐medical ☐behavioral ☐both

ONLY LEAVE ME A MESSAGE AT THIS PHONE NUMBER:
☐medical ☐behavioral ☐both

NEVER SEND ME A TEXT AT THIS PHONE NUMBER:
☐medical ☐behavioral ☐both

ONLY SEND ME A TEXT AT THIS PHONE NUMBER:
☐medical ☐behavioral ☐both

PLEASE REMOVE THIS EMAIL ADDRESS:
☐medical ☐behavioral ☐both

PLEASE ONLY USE THIS EMAIL ADDRESS:
☐medical ☐behavioral ☐both

PLEASE USE THE FOLLOWING SPECIAL INSTRUCTIONS WHEN COMMUNICATING WITH ME:
☐medical ☐behavioral ☐both

PATIENT OR GUARDIAN SIGNATURE ____________ DATE ____________

HOPE Family Health