

DR4ALL MEDICAL, LLC

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____ Patient's Date of Birth: _____
Patient's SSN: _____

Notice to Patient:

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting Dr. Messo.

You have the right to **revoke** your Consent by giving written notice to our Dr. Messo. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this **Consent Form** after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

Patient's Signature or Signature of Patient's Representative

Date

Printed Name of Patient's Representative

Relationship to Patient

Dr. Ralph K. Messo, DO

PO Box 83, Colts Neck, NJ 07722

Phone: 732-539-7007

E-Mail: dr4allmedical@gmail.com

DR4ALL MEDICAL, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because: ☐

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other _____

Employee Signature

Date

I wish to be contacted in the following manner (check all that apply) ☐

- ☐ **Home Phone #** _____
 - ☐ **OK to leave message with detail information**
 - ☐ **Leave message with call-back number only**
- ☐ **Cell/Other Telephone #** _____
 - ☐ **OK to leave message with detail information**
 - ☐ **Leave message with call-back number only**
- ☐ **Written Communication**
- ☐ **OK to email my email address**
- ☐ **Persons authorized to receive information**

Relationship _____

Relationship _____

Printed Name

Patient Signature

_____/_____/_____
Date

DR4ALL MEDICAL, LLC

Dr. Ralph K. Messo, Jr., DO
PO Box 83, Colts Neck, NJ 07722
(732) 539-7007

AUTHORIZATION TO OBTAIN MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

I request and authorize DR4ALL Medical, LLC/Dr. Ralph K. Messo to obtain my protected health information from:

Name: _____

Address: _____

Fax: _____

The information to be released is to include: (indicate dates of treatment and portion of each to be released).

_____ Reports of Operation	_____ Radiologic Interpretation
_____ Consultation Reports	_____ Lab Test Results

Yes___ No___ I authorize the release of any records regarding drug, alcohol, and mental health treatment to the person listed above. If you do not make a selection, these records will be released as part of your records.

Unless otherwise revoked by myself, this authorization is to be considered valid only for 30 days from the date below. If information has been released under the terms of this authorization which I later revoke, I understand that DR4ALL Medical, LLC/Dr. Ralph K. Messo will not be responsible for release prior to receipt of revocation.

Date: _____ Patient Signature: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on November 2, 2020 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Dr. Ralph Messo. Information on contacting us can be found at the end of this notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share our protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established “minimum necessary” or “need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures” of your protected information if the disclosure was made for purposes other than providing services,

payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer.

Right to request Restriction of PHI: If you pay full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013. The Omnibus Rule restricts provider's refusal of an individual's request to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law (Court or administrative orders, subpoena, discovery request or other lawful process). We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

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. This information will be disclosed only to the extent necessary to prevent a serious threat to our health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, and disease /infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we

receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). "Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or fee otherwise expressly permitted by law. Corporate transactions (i.e. sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). We will provide access to health information in a form/format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a complaint form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

DR4ALL Medical, LLC
Dr. Ralph K. Messo, Jr., DO
732-539-7007
Dr4allmedical@gmail.com

www.dr4allmedical.org



DR4ALL Medical, LLC.

Ralph K. Messo, Jr., DO

Date: _____

Last Name: _____ First Name: _____ M: _____

Sex: Male / Female Date of Birth: _____ Social Security: _____

Marital Status: Single / Married / Divorced / Widowed Preferred Language: English / Other _____

Race: White / African American / Other _____ Ethnicity: Hispanic / Non-Hispanic

Address: _____ Town: _____ State Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Preferred Contact: Home / Cell / Work / Email (Circle One)

Emergency Contact Name: _____ Phone: _____

Employer/School: _____ Occupation: _____

Pharmacy Name, Address, Phone: _____

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Date: _____, 20____

- I. THE PATIENT.** This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient's Name: _____

Date of Birth: _____, 20____

Social Security Number: _____ - _____ - _____

- II. AUTHORIZATION.** I authorize _____ ("Authorized Party") to use or disclose the following: (check one)

- ☐ - All of my medical-related information.
- ☐ - My medical information ONLY related to: _____.
- ☐ - My medical-related information from _____, 20____ to _____, 20____.
- ☐ - Other: _____.

Hereinafter known as the "Medical Records."

- III. DISCLOSURE.** The Authorized Party has my authorization to disclose Medical Records to: (check one)

- ☐ - Any party that is approved by the Authorized Party.
- ☐ - ONLY the following party:
- Name: _____
- Address: _____
- Phone: (____) ____ - ____ Fax: (____) ____ - ____
- E-Mail: _____

- IV. PURPOSE.** The reason for this authorization is: (check one)

- ☐ - **General Purpose.** At my request (general).
- ☐ - **To Receive Payment.** To allow the Authorized Party to communicate with me for marketing purposes when they receive payment from a third party.
- ☐ - **To Sell Medical Records.** To allow the Authorized Party to sell my Medical Records. I understand that the Authorized Party will receive compensation for the disclosure of my Medical Records and will stop any future sales if I revoke this authorization.
- ☐ - **Other:** _____.

V. TERMINATION. This authorization will terminate: (check one)

- ☐ - Upon sending a written revocation to the Authorization Party.
- ☐ - On the following date: _____, 20____.
- ☐ - Other: _____.

VI. ACKNOWLEDGMENT OF RIGHTS.

I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ **Date:** _____

Print Name: _____

(IF THE PATIENT IS UNABLE TO SIGN, USE THE SIGNATURE AREA BELOW)

The patient is unable to sign due to: (check one)

- ☐ - **Being a Minor.** Patient is ____ years old and considered a minor under state law.
- ☐ - **Being Incapacitated.** Patient is incapacitated due to: _____.
- ☐ - **Other:** _____.

Signature of Representative: _____ **Date:** _____

Print Name: _____

Relationship to Patient: ☐ Parent ☐ Spouse ☐ Guardian ☐ Other: _____.

ADDITIONAL CONSENT FOR CERTAIN CONDITIONS

- I. **SENSITIVE INFORMATION.** This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

(check one)

☐ - I **consent** to have the above information released.

☐ - I **do not consent** to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____

- II. **HIV/AIDS.** This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

(check one)

☐ - I **consent** to have the above information released.

☐ - I **do not consent** to have the above information released.

Signature of Patient: _____ Date: _____

Print Name: _____