Carson Medical Group

Patient Registration Form

Patient Information

Please note that the patient's name as provided here must match the name on the insurance card in order for claims to be successfully submitted to insurance.

Last Name: _____ First Name: _____ MI: _____

Previous Name: _____

Date of birth: _____ Gender: ☐ Male ☐ Female ☐ Transgender

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Legally Separated

Is the patient a veteran? ☐ Yes ☐ No

Is the patient in foster care? ☐ Yes ☐ No

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address (if different from mailing address): _____

City: _____ State: _____ Zip: _____

		May we leave a detailed message regarding your medical care / treatment at this number?
Home Phone:	( ) -	☐ Yes ☐ No
Cell Phone:	( ) -	☐ Yes ☐ No
Work Phone:	( ) -	☐ Yes ☐ No

I prefer to receive appointment and other reminders as:
☐ Text ☐ Phone call, in the: ☐ Morning ☐ Afternoon ☐ Evening

Please provide your email address below to enroll in Carson Medical Group's Patient Portal

E-Mail Address: _____
(to be used for confidential communication)

Patient's Employer: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not employed ☐ Retired

Race (required)	Ethnicity (required)	Primary Language (required)
☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Other race ☐ Declined to Specify	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify	☐ English ☐ Spanish ☐ Other _____

Emergency Contact

Name: _____ Relationship to patient: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone Number: ( ) -

Pharmacy Information

Pharmacy of Choice: _____

Address/Location (e.g. N. Carson & Winnie): _____

Miscellaneous Information

Do you have an Advance Directive? (check all that apply)

- ☐ Decline
- ☐ Healthcare proxy (POA)
- ☐ No blood transfusions
- ☐ Living Will
- ☐ Advance Directive
- ☐ Physician order for life-sustaining treatment
- ☐ Organ donor
- ☐ Do Not Resuscitate

Is the patient visually impaired? ☐ Yes ☐ No

Is the patient hearing impaired? ☐ Yes ☐ No

Insurance Information

Please be prepared to show your insurance card and identification at every office visit.

Primary Insurance Company: _____

Policy Holder's Name _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Date of birth: _____

Policy/ID Number: _____ Group #: _____

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Secondary Insurance Company: _____

Policy Holder's Name _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Date of birth: _____

Policy/ID Number: _____ Group #: _____

Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Notice to Patients Regarding the Destruction of Health Care Records

Pursuant to the provisions of subsection 7 of NRS 629.051:

1. The health care records of a person who is less than 23 years of age may not be destroyed; and
2. The health care records of a person who has attained the age of 23 years may be destroyed for those records which have been retained for at least 5 years or for any longer period provided by federal law; and
3. Except as otherwise provided in section 7 of NRS 629.051 and unless a longer period of time is provided by federal law, the health care records of a patient who is 23 years of age or older may be destroyed after 5 years pursuant to subsection 1 of NRS 629.051.

Consent to Access External Prescription History

_____ By initialling here, I am granting my consent for Carson Medical Group to access my prescription history. I understand that prescription history from multiple, other, unaffiliated medical providers; insurance companies; and pharmacy benefit managers may be available to providers and staff here and that it may include prescription history dating back several years.

Acknowledgement

All of the above information is true to the best of my knowledge. I authorize Carson Medical Group to release my information to insurance carriers concerning my medical condition/treatment, etc. in order to facilitate claims payment. In addition, I assign benefits to be paid to Carson Medical Group for all services rendered. I understand that I am financially responsible for charges for medical services rendered to the above named patient regardless of insurance coverage/payment. I understand that all co-payments and or deductible amounts are due and payable at the time of service.

_____

Patient Name (Please print)

_____ _____

Patient Signature Date

Rev 07/14/2020

By typing your name for your signature, you are signing this form electronically.
You agree your electronic signature is the legal equivalent of your manual signature on this form.

Carson Medical Group

Financial Policy

It is Carson Medical Group's goal to promote health by providing the finest in family medical care. We care for our patients and our community. Everyone will be treated professionally and compassionately with dignity and respect. This goal is best achieved if everyone is informed of the financial policy, which is an agreement between Carson Medical Group and you as the patient, or patient's parent/guardian. Your clear understanding of the financial policy is essential to our professional relationship. Please read the following agreement, and initial to acknowledge your agreement and understanding. If you have questions regarding any of the sections, please do not hesitate to ask your Patient Service Representative:

Insurance

1. Health insurance is a contract between you and your insurance company. It is the patient's responsibility to understand your healthcare benefits. For example, financial liability, acceptable facilities for diagnostic testing (lab, X-Ray, etc.), whether or not authorization is required for certain services, and/or covered services under your plan.
2. As a courtesy to our patients, Carson Medical Group will bill *most* insurance payers on our patient's behalf, but it is the patient's sole responsibility to ensure Carson Medical Group is an in-network provider with their plan.
    a. In order to successfully bill your insurance, you will be required to present your insurance card at each time of service as well as your photo ID to ensure patient identity.
3. Carson Medical Group requires payment at the time of service for any estimated patient responsibility, including co-pays, co-insurance, remaining deductible, uninsured patients and/or past due balances.
    a. Carson Medical Group treats all patients fairly when collecting account balances. In accordance with federal regulations, and contractual obligations with third-party payers, Carson Medical Group does not waive, fail to collect, or discount co-payments, co-insurance, deductible, or any other patient financial responsibility.
4. If Carson Medical Group is your primary care physician, please make sure you have updated this information with your insurance company, as some health plans may deny claims and hold you financially responsible for your visit.
5. It is patient responsibility to disclose any other coverage that may be in addition to the primary coverage. If you have more than one insurance, you must ensure the coordination of benefits with all payers, to determine which designated primary, secondary, and/or tertiary is. Failure to do so may result in patient financial responsibility.
6. Carson Medical Group does not treat for Worker's Compensation claims. You will need to contact your employment supervisor for instructions on where you can seek treatment.
7. Carson Medical Group does not treat automobile or third-party liability claims. You will need to contact the insurance carrier that is responsible for coverage for instructions on where you can seek treatment.

Initial: _____

Carson Medical Group

Payments

1. Carson Medical Group collects an *estimated* payment at the time of check-in based on the average service level, and your insurance's allowable amount when available, however this is only an estimate. Should more services be rendered (i.e. higher level visit, testing, procedures, or injections) you will receive a statement for the additional care after your insurance processes your claim. In order to mitigate any disruption in care, we require prompt payment upon statement receipt.
    a. Non-Emergent appointments may be rescheduled if there are outstanding balances or if a co-payment is not made at time of service. If you are experiencing financial difficulty, please let us know and we will do our best to work with you.
2. Carson Medical Group will return all monies that are not due to the Practice.
    a. Should you have made an overpayment to Carson Medical Group, and you paid with credit or debit card, we will promptly, automatically return any overpayment amount directly to the card used on date of payment.
    b. Should you have made an overpayment to Carson Medical Group, and you paid with check or cash, we will promptly, automatically issue a refund check if the amount is over $5.00. Any amount for $4.99 or less will remain on your account and applied to a future visit or you may request this be refunded to you.

Initial: _____

Fees

1. Carson Medical Group will impose a fee of $25.00 for checks or credit card transactions that are not processed due to insufficient funds.
2. Carson Medical Group will impose a fee of $30.00 for costs related to reissuing a lost, stolen, or expired check.

Initial: _____

I have read and understand the above Financial Policy of Carson Medical Group. I accept the responsibility outlined. I give permission for Carson Medical Group to bill my insurance on my behalf, and accept payment for the services rendered. I also give permission for the Business Office of Carson Medical Group to contact me on my most current listed contact information as it relates to debt collection when necessary.

_____ _____

Signature Date

_____ _____

Patient's Name (print) Patient's Date of Birth

By typing your name for your signature, you are signing this form electronically.
You agree your electronic signature is the legal equivalent of your manual signature on this form.

Carson Medical Group

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.

If you have any questions about this notice, please contact your physician or our administrator.

Our Obligations *We are required by law to: Maintain the privacy of protected health information, give you this notice of our legal duties and privacy practices regarding health information about you, and follow the terms of our notice that is currently in effect.*

Immunizations ***In accordance with the Modification to HIPAA Rules dated March 26, 2013 parents and guardians may provide a general permission for health care providers to disclose student immunization records to schools, preschools, and daycare facilities upon the school's request that are mandated by the State of Nevada to ensure attending students are vaccinated. A parent or guardian's signature on this Notice of Privacy Practices shall serve to accomplish this general written permission for release of a child's immunization record upon school requests.***

How We May Use and Disclose Health Information

Described as follows are the ways we may use and disclose Health Information that identifies you ("Health Information"). Except for the following purposes, we will use and disclose Health information only with your written permission. You may revoke such permission at any time by writing to our practice's privacy officer.

Treatment We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Health Care Operations We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetric or gynecologic care you receive is of the highest quality. We may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Payment We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may share your health plan information so that another party will pay for your treatment.

Your Rights

As Required by Law We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates We may disclose Health Information to our business associates who perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Military and Veterans If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury, or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Your Rights Continued...

Coroners, Medical Examiners and Funeral Directors We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement We may release Health Information if asked by a law enforcement official if the information is: 1) in response to a court order, subpoena, warrant, summons or similar process; 2) limited information to identify or locate a suspect, fugitive, material witness or missing person; 3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the persons' agreement; 4) about a death we believe to be result of criminal conduct; 5) about criminal conduct on our premises; and 6) in an emergency to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National Security and Intelligence Activities We may disclose Health Information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Protective Services for the President and Others We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made necessary: 1) for the institution to provide you with health care, 2) to protect your health and the safety or the health and safety of others, or 3) for the safety and security of the correctional institution.

Organ and Tissue Donation If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye, or tissue donation; and transplantation.

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records other than psychotherapy notes. To inspect and copy this Health Information, you must make your request in writing to your physician.

Right to Amend If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request in writing to your physician.

Right to Request Restrictions You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request in writing to your physician or our administrator. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication You have the right to request that we communicate with you about medical matters in a certain way or a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make your request in writing to your physician or our administrator. Your request must specify how or where you which to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice contact your physician or our administrator.

Right to an Accounting of Disclosures You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provide written authorization. To request an accounting of disclosures, you must make your request in writing to our administrator.

Changes To This Notice We reserve the right to make changes to this notice at any time, and such changes would apply to Health Information already on file as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date in the lower right-hand comer.

Complaints If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our administrator. All complaints must be made in writing. You will not be penalized for filing a complaint.

Notice to Patients Regarding the Destruction of Health Care Records

Pursuant to the provisions of subsection 7 of NRS 629.051:

1. The health care records of a person who is less than 23 years of age may not be destroyed; and
2. The health care records of a person who has attained the age of 23 years may be destroyed for those records which have been retained for at least 5 years or for any longer period provided by federal law; and
3. Except as otherwise provided in section 7 of NRS 629.051 and unless a longer period of time is provided by federal law, the health care records of a patient who is 23 years of age or older may be destroyed after 5 years pursuant to subsection 1 of NRS 629.051.

Print Patient's Name_____ Patient Date Of Birth_____

Patient Signature_____

Guarantor/Guardian Signature_____ Relationship _____

Print Guarantor/Guardian Name_____

Date Signed _____ ☐ Patient refused to sign

By typing your name for your signature, you are signing this form electronically. You agree your electronic signature is the legal equivalent of your manual signature on this form.

Carson Medical Group

Consent to Disclose Protected Health Information

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

I understand that NO PROTECTED HEALTH INFORMATION (other than as outlined by the Health Insurance Portability and Accountability Act) can be released to anyone, including spouses, parents, other family members, significant others, or friends, without this authorization. Please include them below if you would like to designate additional individuals to have this access.

A minor patient's parents or legal guardians will have access to the child's medical information, except when prohibited by law.

By signing this authorization, I authorize Carson Medical Group to disclose protected health information about me/my child to the following individual(s).

Please list each individual and mark the type of access you would like each individual to have.

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Pick Up Medical Records ☐ Accompany to Visits and Consent for Treatment (Minors only)

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Pick Up Medical Records ☐ Accompany to Visits and Consent for Treatment (Minors only)

Name: _____ Relationship: _____

☐ Appointment Information ☐ Billing Information ☐ Detailed Medical Information ☐ Pick Up Medical Records ☐ Accompany to Visits and Consent for Treatment (Minors only)

This authorization has no expiration date. It shall be terminated when withdrawn in writing or when an updated form has been completed.

Patient/Parent/Legal Guardian Signature: _____ **Date Signed:** _____

Parent/Legal Guardian Name: _____
(Minors Only) (Please Print)

Carson Medical Group

Gynecology Health History Form

Patient Name _____ Date of Birth _____

Gender Identification/Preferred Pronoun _____

Social History

Marital Status ☐ Single ☐ Married ☐ Long-term relationship ☐ Divorced ☐ Widowed

Reason for Visit _____

Primary Care Provider _____

Occupation _____

Menstrual History

Age at first menstrual period _____ Age of menopause _____ First day of last menstrual period _____

If your menstrual periods are regular; periods start every _____ days

If your menstrual periods are irregular; periods start every _____ to _____ days (e.g., 12 to 60)

Duration of bleeding _____ days Flow is ☐ Heavy ☐ Regular ☐ Light

Is pain associated with periods? ☐ Yes ☐ No ☐ Occasionally

If yes, is it? ☐ Before menses ☐ During menses ☐ Both

Pregnancy History (all pregnancies) Including abortions & ectopic (tubal) pregnancies.

☐ Have never been pregnant

Year	**Location**	**Pregnancy Duration**	**Delivery Type** (Cesarean/ Vaginal)	**Complications** (Mother/Infant)	**Sex** (Male/Female)	**Birth Weight**

Birth Control History

What birth control method(s) do you currently use (including vasectomy)? _____

Sexual/GYN History

Do you have a sexual partner? ☐ Yes ☐ No

If yes: ☐ Male ☐ Female ☐ Both

Please check any that apply or ☐ None

☐ Herpes-genital ☐ Syphilis ☐ Pelvic inflammatory disease ☐ Vaginal infections ☐ Endometriosis

☐ Chlamydia ☐ Gonorrhea ☐ Sexual abuse ☐ HPV ☐ Other _____

Past Obstetrical/Gynecological Surgeries

Check all that apply or: ☐ None

Surgery	Year	Surgery	Year
☐ Dilation & Curettage (D&C)		☐ Myomectomy (Fibroid Removal)	
☐ Hysteroscopy		☐ Ovarian Surgery	
☐ Infertility Surgery		☐ Left Ovary Removed	
☐ Tubal Ligation		☐ Right Ovary Removed	
☐ Laparoscopy		☐ Vaginal or Bladder Repair for Prolapse or incontinence	
☐ Hysterectomy (Vaginal)		☐ Cesarean Section	
☐ Hysterectomy (Abdominal)		☐ Other	

Past Surgical History (non-Obstetrical/Gynecological)

Please list all surgeries and year or: ☐ None **Year**

PAP Smear/Mammogram History

Date of last PAP smear _____ Have you had an abnormal PAP smear? ☐ Yes ☐ No

Have you had treatment for an abnormal pap smear? ☐ Yes ☐ No

If yes, what type of treatment? ☐ Cryotherapy ☐ Cone Biopsy ☐ Loop Excision (LEEP)

Year of treatment _____

Date of last mammogram *(month & year)* _____ Have you had an abnormal mammogram ☐ Yes ☐ No

Past Medical History

Check all that apply or: ☐ None

☐ Diabetes	☐ Liver Disease *(Including Hepatitis)*	☐ HIV+
☐ High Blood Pressure	☐ Epilepsy or Seizure Disorder	☐ Eating Disorder
☐ Heart Disease	☐ Blood Clots	☐ Anxiety or Depression
☐ Kidney Disease	☐ Thyroid Disease	☐ Migraines
☐ Gallstones	☐ Asthma	☐ Cancer Type: _____

Medication Allergies

Do you have allergies to medication? ☐ Yes ☐ No

If yes, please list medications and reaction _____

Current Medications (Include dose/amount per day)

Medication	Dose/Amount	Frequency

Do you currently?

Smoke or Vape ☐ Yes ☐ No If yes, number of packs per day? _____

Use Marijuana ☐ Yes ☐ No If yes, how much and how often? _____

Use Alcohol ☐ Yes ☐ No If yes, how much and how often? _____

Use Illicit Drugs ☐ Yes ☐ No If yes, how much and how often? _____

Preventative Care

When was your last?

	Date		Date		Date
Colonoscopy		Flu Vaccine		Gardasil Vaccine	
DEXA (bone density) Scan		Tdap Vaccine		Shingles Vaccine	
Labs		Pneumonia Vaccine		COVID Vaccine	

Family History

Do you have family history of the following? *If yes, please indicate which family member.*

	Family Member		Family Member
☐ Blood Clots		☐ Uterine Cancer	
☐ Diabetes		☐ Breast Cancer	
☐ Heart Disease		☐ Colon Cancer	
☐ Ovarian Cancer			
☐ Other Family History:			

STOP here if you are not pregnant

If you are currently pregnant, or planning pregnancy in the near future, please continue.

Genetic History

Have you/the father ever had genetic carrier screening? ☐ Yes ☐ No

Are you/the father Italian, Greek, Mediterranean, Asian, African American or Ashkenazi Jewish? ☐ Yes ☐ No

Are you and the father blood related? ☐ Yes ☐ No

Do you/the father have family history of any genetic or chromosome disorders? ☐ Yes ☐ No

If yes, what disorders and what are the relationships to you/the father? _____

Patient Consent Form

For Electronic Exchange of Individual Health Information

HealtHIE Nevada is a nonprofit organization that connects the health care community and enables the sharing of information electronically and securely to improve the quality of health care services. To learn more about the health information exchange (HIE), read the **Patient Information Brochure**. You can ask the doctor that gave you this form for it, or you can visit the website at www.healtHIEnevada.org.

Details about patient information in HealtHIE Nevada and the consent process:

1. **How your information will be used and who can access it:** When you provide consent, only HealtHIE Nevada participants (such as doctors, hospitals, laboratories, radiology centers and pharmacies), will have access to your health information. It can only be used to:
   - Provide you with medical treatment and related services
   - Evaluate and improve the quality of medical care provided to all patients, using de-identified health information

2. **Types of information included and where it comes from:** The information about you comes from participating organizations that have provided you with medical care. These may include hospitals, physicians, pharmacies, clinical laboratories and other health care organizations. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medications your doctor has prescribed. This may include information created before the date of this **Consent Form**. This information may relate to sensitive health conditions, including, but not limited to:
   - Alcohol or drug use problems
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Birth control and abortion (family planning)
   - Sexually transmitted diseases

3. **Improper access or disclosure of your information:** Electronic information about you may be disclosed by a participating doctor to others only to the extent permitted by Nevada state law. If at any time you suspect that someone who should not have seen or received information about you has done so, you should notify your doctor.

4. **Effective period:** Your consent becomes effective upon signing this form and will remain in effect until the day you revoke it or HealtHIE Nevada ceases to conduct business.

5. **Revoking your consent:** You may revoke your consent at any time by signing a new consent form and giving it to your doctor. These forms are available at your doctor's office, or by calling 855-484-3443. Changes to your consent status may take 24-48 hours to become active in the system.

   Note: Organizations that access your health information through HealtHIE Nevada while your consent is in effect may copy or include your information into their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

6. **How your information is protected:** Federal and state laws and regulations protect your medical information. HIPAA, the Healthcare Insurance Portability and Accountability Act of 1996, is the federal law that protects your medical records and limits who can look at and receive your health information, including electronic health information. HIPAA's protections were further strengthened by another federal law, the HITECH Act of 2009, which may impose severe financial fines on anyone who violates your medical privacy rights. All health information made available on the HIE, including your medical information, is encrypted to federal standards and is accessible only as allowed by Nevada state law (NRS 439.590). In addition, your doctor must provide you with a Notice of Privacy Practices, which describes how he or she uses and protects your medical information.

You are entitled to receive a copy of this **Consent Form** after you sign it.

Patient Consent Form for Electronic Exchange of Individual Health Information

Please read through the consent form and provide the following information: (Please print)

PATIENT NAME

Last *First* *Middle*

PREVIOUS NAME(S)_____ **GENDER:** M☐ F☐

STREET ADDRESS/P.O. BOX_____

CITY_____ **STATE**_____**ZIP CODE**_____

PHONE NUMBER_____**EMAIL**_____

DATE OF BIRTH_____(MM)_____(DD)_____(YYYY)

☐ **Nevada Medicaid Patients: PLEASE READ.** Nevada law mandates that "a person who is a recipient of Medicaid or insurance pursuant to the Children's Health Insurance Program may not opt out of having his or her individually identifiable health information disclosed electronically" (NRS 439.539). When a patient is no longer a Medicaid recipient, it is her/his responsibility to change their consent choice, if they choose to do so. Please sign below to indicate your acknowledgement.

Consent Choices: (CHECK ONE) Nevada Medicaid Patients are exempt from making a selection.

Your choice to give or to deny consent may not be the basis for denial of health services.

☐ **I CONSENT** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) in connection with providing me any health care services, including emergency care.

☐ **I CONSENT ONLY IN CASE OF AN EMERGENCY** for all HIE participants to access **ALL** of my electronic health information (including sensitive information) **ONLY** in the event of a medical emergency.

☐ **I DO NOT CONSENT** for any HIE participants to access **ANY** of my electronic health information **EVEN** in the event of a medical emergency.

_____ _____

Signature of patient, parent/legal guardian, or authorized representative Date

**If I sign this form as the patient's authorized representative, I understand that all references in this form to "I," "me" or "my" refer to the patient.*

_____ _____

Name of parent/legal guardian or authorized representative (printed) Relationship to patient

_____ _____

Address of authorized representative Phone number