SUNNYSIDE
DIRECT PRIMARY CARE

Patient _____ **DOB** _____

Instructions: The following section to be completed by office. Last section to be completed by Patient or Guardian.

Release Information From	Release Information To
○ Other (*Specify facility/individual & address below, including phone/fax if known*) _____ _____	○ Sunnyside DPC, 1432 Dr. MLK Jr., St. N., St. Petersburg, FL 33704 Phone: (727) 314-6472 Fax: (727) 619-2310 Dr. Brett Levine & Dr. Alex Bugg

○ Treatment/Continued care ○ Application for insurance ○ Personal ○ Disability determination	○ Legal purposes ○ Payment of Insurance Claims	○ Other _____ _____

Information To Be Released		
(Required: Check all that apply) ○ Clinic notes ○ History and physical ○ Hospital notes ○ Hospital discharge summary	○ EKG's ○ Immunization records ○ Laboratory reports ○ Operative reports	○ Pathology reports ○ Radiology reports ○ Radiology images ○ Billing information ○ Other (*specify information to be released below*) ○ Entire Chart

Service dates (optional)
From To Information needed by (optional)

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law**. Information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and may no longer be protected by federal law.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing**, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ❑Legal Guardian or Conservator ❑ Health Care Agent (Health Care Power of Attorney)
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:
  ❑Parent ❑ Legal Guardian

Signature (*Required*)	**Date Signed** (*Required*)
Printed Name of Person Signing (if not patient)	

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Patient **DOB**

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health

information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations. We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.



- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received the Notice of Privacy Practices.

_____

Patient (Print)

_____ _____

Patient Signature **Date**

Consent for Photographing or Other Recording for Security and/or Health Care Operations

_____ I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

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RIGHT TO SHARE INFORMATION WITH FAMILY AND FRIENDS

Sunnyside DPC reserves the right to communicate PHI with family or friends when it is deemed to be in the best interest of the patient as described in the Notice of Privacy.

In order to have your PHI shared in other circumstances with members of your family or friends, please list those individuals who Sunnyside DPC is authorized to release information to:

_____

_____

_____

_____

_____

Patient Signature **Date**

ALTERNATIVE COMMUNICATION RELEASE FORM

I authorize LevMed, in regard to my protected health information (PHI): (√ *all that apply*)

____To call me at work
____To call me at home
____To call my cell phone
____To send me a message via text messaging
____To contact me via video telephone interface (telemedicine)
____To speak with anyone listed on the Right To Share Information list
____To only speak with me
____To fax information to me at this secured number
____Other

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Authorization to Release Protected Information

Notification of Controlled Substances

While Sunnyside DPC is able to prescribe necessary scheduled medications, it is important to disclose our philosophy regarding some of the stronger — and potentially harmful — pain relief medications. Sunnyside DPC is aware of the potential side effects of this class of medication (particularly benzodiazepines and opiates) and will do our best to curb their use or find less potentially harmful pharmacological options. Please do not join Sunnyside with the assumption that Dr. Levine or Dr. Bugg will fill controlled substances on the initial visit. If certain chronic pain narcotics are necessary, Sunnyside will refer out to a local pain management specialist. Candidly, if you are expecting Sunnyside to prescribe high dose narcotics such as opiates, Sunnyside may not be the right practice for you.

Patient Signature	**Date**

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Patient No-Show Policy and Procedure

Sunnyside DPC provides standards for scheduling patient appointments that help enhance patient care. Please understand that our appointment times are scheduled to allow us to take care of each patient's individual needs during the patient's visit. To promote efficient access to our office, we require that any appointment that is no longer needed or unable to be kept must be cancelled more than 24 hours in advance.

In the event an appointment is missed or cancelled with less than 24 hours' notice or no notice, Sunnyside DPC follows the process below.

- **1st missed appointment**: We will contact you and reschedule the appointment
- **2nd missed appointment**: We will contact you and offer to reschedule. You will receive an email explaining our policy, and you may be charged a missed appointment fee of up to $35.
- **3rd missed appointment**: This could result in discharge from our practice. You may be asked to find another physician outside of Sunnyside DPC.

Our main concern is to manage your healthcare with the highest quality skill and efficiency we can offer. If you have question, our staff will be happy to answer them.

Patient Signature **Date**