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Putnam Pediatrics and Internal Medicine
1542 S Bloomington St
Greencastle, IN 46135
Phone: 765-658-2700
Fax: 765-658-2703

PLEASE BE ADVISED OF THE FOLLOWING:

1. It is the policy of this office to **NOT PRESCRIBE CONTROLLED SUBSTANCES** for chronic pain conditions or medications normally managed by a psychiatrist. We urge you to contact your insurance company case management department to have them assist you in finding a physician that will help you manage those conditions.

2. It is our goal to see all patients on time. The providers strive to not keep anyone waiting unnecessarily. We ask that you assist us in this by always arriving at your scheduled appointment **15 MINUTES** early. Not being on time may result in your being seen later in the day or having to reschedule for a later date.

3. We have a strict **NO SHOW NO CALL** policy. We request you always let us know 24 hours in advance if you are not going to be able to keep an appointment. This allows us to use the time for other appointments and assists us with having space for acutely ill patients. A habit of not calling ahead of time to cancel an appointment will result in being discharged from the practice.

PATIENT PRINTED NAME_______________________________

DATE________________

SIGNATURE OF PATIENT OR GUARDIAN

____

Authorization For Release of Patient Health Information

RELEASE RECORDS FROM: ______________________________
____
____

I AUTHORIZE THESE PRACTICES LISTED ABOVE TO RELEASE THE BELOW INFORMATION FROM MY HEALTH RECORD(S).

Patient Name (Please Print):______________________________Date of Birth:__________
Patient Address:______________________________ Patient Phone #:______________
Last 4 Digits of Social Security #:______

Covering the period(s) of treatment:______________________________

INFORMATION TO BE RELEASED:

______ Progress Note (Date):______________________________
______ Radiology (X-ray, CT Scan, MRI) _____Lab Results _____EKG _____Procedure Note _____Consultations
______ HCFA 1500/Billing _____ Immunization _____Abstract Of Health Records _____Complete Record
______ Other (specify):______________________________

INFORMATION TO BE RELEASED TO:

Putnam Pediatrics and Internal Medicine
1542 S. Bloomington St.
Greencastle, Indiana, 46135
765-658-2700 (Phone) 765-658-2703(Fax)

PURPOSE OF DISCLOSURE: ___Continuation of Care ____ Insurance____ Attorney____ Personal Use ___ Other

I understand this authorization can be revoked by me at any time in writing to the practices listed above except that disclosure made in good faith has already occurred in reliance on this authorization. Putnam Pediatrics & Internal Medicine will not condition treatment, payment, enrollment or eligibility for benefits on whether this authorization is signed except as allowed under the HIPPA regulations.

<u>I understand that a fee may be charged for preparing a copy of the requested records.</u> I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:______________________________.
If I fail to specify an expiration date, event, or condition, this authorization will expire in 60 days.

Your protected health information will be provided to you in paper format. I understand that this release also pertains to records regarding the testing and treatment **for alcohol/substance abuse, human immunodeficiency virus (HIV), and/or AIDS, or for psychiatric treatment or counseling or communicable disease, unless I have initialed here:__________________.**

SIGNATURE:______________________________ DATE:______________

RELATIONSHIP TO PATIENT, if other than patient:______________________________

DESCRIPTION OF AUTHORITY TO ACT FOR PATIENT (if applicable):______________________________

WITNESS SIGNATURE:______________________________ DATE:______________

Patient Name: ______________________
Account#: ______________________
Medical Record#: ______________________

Release of Information

Putnam County Hospital

NOTICE OF PRIVACY PRACTICES
PHYSICIAN 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

USES AND DISCLOSURES
TREATMENT: Your health information may be used by staff member or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.
PAYMENT: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.
HEALTHCARE OPERATIONS: Your health information may be used as necessary to support the day-to-day activities and management of Putnam County Hospital Physician Practices. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.
LAW ENFORCEMENT: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigation, and to comply with government-mandated reporting.
PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.
OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USE OF INFORMATION
Appointment reminders: Your health information may be used by our staff to send you appointment reminder.
Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of you medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

INDIVIDUAL RIGHTS
You have certain rights under the federal privacy standards. These include:

*the right to request restrictions on the use and disclosure of your protected health information
*the right to receive confidential communications concerning your medical condition and treatment.
*the right to inspect and copy your protected health information
*the right to amend or submit corrections to your protected health information
*the right to receive an accounting of how and to whom your protected health information has been disclosed
*the right to receive a printed copy of this notice