

# LAFAYETTE CLINIC, PA

## Notice of Privacy Practice

Patient Name: \_\_\_\_\_

LaFayette Clinic respects the privacy of its patients, whether the information is medically related or not. As a patient of LaFayette Clinic, it will be necessary to provide our facility and its physicians with personal information such as name, address, birthday, and health insurance information as well as a thorough medical history.

Our office will use this information for the purpose for which it has been provided: in providing for your medical care and treatment, and in filing claims for your insurance benefits for charges as a result of your medical treatment with our clinic. Our office may also find it necessary to use this information should it be necessary to care for you while you are in the hospital as an outpatient or inpatient.

It may be necessary for us to provide your diagnosis or health history when scheduling procedures or referring you to other health care facilities. Any and all information between our office and our medical billing vendor is exchanged using Internet Security Protocols to help us maintain a high standard of privacy.

We may use or disclose, as needed, your protected health information in order to support the business activities of the office. For example: we use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you or you are needed at the front desk. We also use an automated service to call and remind patients of their appointments.

### **Patient Consent to Release Information**

I hereby authorize LaFayette Clinic, its physicians and employees to release any information acquired in the course of my examination or treatment to my insurance carrier, third party payers, or others involved in the processing and collection of my insurance claims. I understand and authorize this information to be forwarded either by phone, fax, mail or electronic transmission. I understand it is my responsibility to advise LaFayette Clinic when my insurance carrier changes.

I further authorize LaFayette Clinic, its physicians and employees to release personal and health information as necessary to my referring physicians and/or family physician and their offices, and to medical offices and facilities as necessary in the scheduling of studies as ordered by LaFayette Clinic's physicians and providers. I understand and authorize this information to be forwarded either by fax, phone, mail, or electronic transmission. I understand it is my responsibility to advise LaFayette Clinic if my referring or family physician changes to assure records are forwarded to the appropriate doctor. I understand I can revoke this authorization at any time by providing a written, signed statement for my file.

\_\_\_\_\_  
Patient Signature (or parent if patient is under 18)

\_\_\_\_\_  
Date