Prima CARE P.C.

CONSENT TO DISCLOSE HEALTH INFORMATION FOR PAYMENT, TREATMENT AND HEALTH CARE OPERATIONS

Patient Name: _____ Date of Birth: _____
Last *First* *Middle Initial*

Home Address: _____

City: _____ State: _____ Zip _____ Email: _____

Home Telephone: _____ Cell: _____

ACKNOWLEDGMENT OF RECEIPT OF PRACTICE'S NOTICE OF PRIVACY PRACTICES:
By my signature below, I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION:
By my signature below, I hereby authorize the Practice to disclose my medical information so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations (e.g., quality assurance). I also authorize the Practice to disclose my medical information to insurers and providers outside of the Practice when necessary so that these providers may treat me, seek payment for that treatment, and for the purpose of their health care operations. **I also authorize the Practice to disclose my medical information on my home answering machine/voicemail and to my spouse, children, and the following additional family and friends:** _____

This consent shall remain in full effect while you remain under the care of any Prima CARE P.C. physician.

MY HIGHLY CONFIDENTIAL INFORMATION:

I understand that my medical record currently contains or may contain in the future the following types of highly confidential information. By my signature below, I specifically consent to the disclosure of such information as part of my medical record to insurers and providers outside the Practice for the purpose of obtaining treatment for me, payment for the treatment provided to me, and so that these entities can carry out their health care operations:

- information about HIV/AIDS status
- information about genetic testing
- information about venereal disease(s)
- mammography records
- information about family planning services or abortion consent forms
- information related to mental health community program records
- information about treatment for substance abuse (alcohol or drug)
- if I am an emancipated minor, information about my treatment and diagnosis (except to my parents)
- information related to confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other allied mental health professional or human services professional

Note to patient: Please strike any of the above-listed bullet points, to the extent you do not want the information disclosed by the Practice.

Massachusetts law requires providers to report immunization information to a computerized immunization registry known as the Massachusetts Immunization Information System (MIIS). The MIIS stores immunization records for you and your healthcare provider and can help prevent outbreaks of disease like measles and the flu. All information in the MIIS is kept secure and confidential. The MIIS allows information to be shared with healthcare providers, school nurses, local boards of health, and state agencies concerned with immunization. You have the right to object to the sharing of your immunization information across providers in the MIIS.
For more information, please visit the MIIS website at www.mass.gov/dph/miis or contact the Massachusetts Immunization Program at 617-983-6800 or 888-658-2850.

_____ _____
Signature of Patient *Date*

If patient is an unemancipated minor or otherwise incapacitated (physically or mentally), obtain the following signatures:

_____ _____ _____
Signature of Personal Representative *Description of Authority* *Date*

Prima CARE PC is committed to safeguarding your personal information, but cannot guarantee protection against all security threats. Prima CARE PC shall not be responsible for any harm caused by a breach of confidentiality in respect to your use of Prima CARE's message system unless the breach was caused by Prima CARE.

By providing a cell phone number or e-mail address to Prima CARE PC, you agree to receive reminders, scheduling information, and Health Portal notifications. By providing this information, you are certifying that you are over eighteen (18) years of age, are (a) the patient or (b) the patient's legal guardian.

Terms and Conditions: Message and data rates may apply. Message frequency depends upon account settings. Call your Prima CARE physician's office for help or assistance.