

Westside Internal Medicine, LLC

HIPAA Privacy Authorization Form

I, _____ (patient/guardian name) allow Westside Internal Medicine, LLC to release information about my care in the following manner (information will not be released in any other matter without patient/guardian consent):

- | | |
|------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> To only me personally | <input type="checkbox"/> On my voicemail |
| <input type="checkbox"/> By mail/email | <input type="checkbox"/> To my spouse _____ |
| <input type="checkbox"/> To my parent _____ | <input type="checkbox"/> Other (specify) _____ |

1. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment or other purposes as I may direct.
2. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest a claim.
3. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
4. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient Signature

Printed Name

Date

Prescription Medication Consent

The providers at Westside Internal Medicine, LLC use an electronic medical record system that allows electronic prescribing of medications. This system also has the ability to access any other medication history prescribed in the past from other providers. Please check one of the following:

- I **do** allow access to my medication history
 I **do not** allow access to my medication history

Patient/Guardian Signature _____ Date _____

Agreement to Bring In Medicine Bottles

I, _____, agree to bring my medication bottles to all my appointments. I understand that failure to do so will prevent me from getting any refills. I will have to come back for another appointment and pay a separate co-pay if I want refills on my Medicine.

Patient Signature _____ Date _____