Acknowledgment of Receipt of Notice of Privacy Practices for Tamara Weiss, M.D., LLC and WRS Electronic Health Record Combined

I, _____, acknowledge that I received a copy of the
(client name)
Notice of Privacy Practices for Tamara Weiss, M.D., LLC.

_____ _____

Signature of Client or Personal Representative Date

If not the client, please print name and state legal authority to sign for client.

----------*For Practitioner Use Only*----------

I attempted to obtain written acknowledgment of receipt of Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining acknowledgment
- Client was incapable of signing
- Other (Specify)_____
  _____

_____ _____

Signature of Practitioner Date

1772 A Century Blvd
Atlanta GA 30345 (678) 996-5902 tweiss@atlpsychiatrist.com

Consent for Treatment

I, _____, acknowledge that I have received a copy of the Consent for
(print – client name)
Treatment form for Tamara Weiss, M.D., LLC (revision date 9/14/17). By signing below, I certify that I have read and understand the terms stated in the Treatment Consent Form. I understand the scope of the services, session structure, cancellation/no-show policies, payment policy, the nature of Dr. Weiss' practice, and her contact information, and I agree to abide by the terms stated above during the course of our therapeutic relationship.

_____ _____

Signature of Client or Personal Representative Date

If not the client, please print name and state legal authority to sign for client below.

_____

1772 A Century Blvd
Atlanta GA 30345 (678) 996-5902 tweiss@atlpsychiatrist.com

Consent Form For ePRESCRIBE PROGRAM/drug history consent

I, _____, acknowledge that I received a copy of the Consent
(print – client name)
form for the ePrescribe Program/drug history consent. By signing below, I certify that I have read and understand and agree to the terms stated in the ePrescribe consent form.

_____ _____
Signature of Client or Personal Representative Date

If not the client, please print name and state legal authority to sign for client below.

1772 A Century Blvd
Atlanta GA 30345 (678) 996-5902 tweiss@atlpsychiatrist.com

Assignment of Benefit Agreement

I, _____, hereby authorize my insurance company to make
(print – client name)
payments to Tamara Weiss MD LLC for medical or surgical services or items rendered to me or my dependent by Tamara Weiss MD LLC. Should my insurance carrier deny Tamara Weiss MD LLC payment, I understand that I am financially responsible for the charges. I authorize Tamara Weiss MD LLC to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal, insurance and health information**.**

_____ _____

Signature of Client or Personal Representative Date

If not the client, please print name and state legal authority to sign for client below.

1772 A Century Blvd
Atlanta GA 30345 (678) 996-5902 tweiss@atlpsychiatrist.com

NOTICE OF PRIVACY PRACTICES OF

Tamara Weiss, M.D., LLC and WRS (electronic healthrecord) Combined

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED (pursuant to the Health Insurance Portability and Accountability Act of 1996 and related regulations) AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective September 3, 2019

If you have any questions or requests about this Notice, please contact Dr. Weiss at 678-996-5902

My Practice is required by State and Federal law to maintain the privacy of protected health information. In addition, the Practice is required by law to provide clients with this Notice of Privacy Practices explaining our legal duties and privacy practices with respect to your medical/mental health information, and to request that you sign the attached written acknowledgment that you received a copy of this Notice. This Notice describes how the Practice may use and disclose your protected health information. This Notice also describes your rights regarding your protected health information and how you may exercise your rights. Protected Health Information, PHI, is information the Practice has created or received about your physical or mental health condition, the health care we provide to you, or the payment for your health care; it may also contain information about HIV status, sexually transmitted diseases, and substance use. Your PHI identifies you or could be reasonably used to identify you. It includes, but is not limited to, your identity, diagnosis, dates of service, treatment plan, intake note, progress notes, and information about your progress in treatment. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION Permissible Uses and Disclosures Not Requiring Your Written Authorization Your medical and mental health information may be used and disclosed in the following ways.

• Treatment: Your medical and mental health information may be used and disclosed in the provision and coordination of your healthcare. For example, this may include coordinating and managing your health care with other health care professionals. Your medical and mental health information may be used and disclosed when I consult with another professional colleague, or if you are referred for medication, or for coverage arrangements during my absence. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician. In any of these instances only information necessary to complete the task will be provided.

• Payment: Your mental health care information will be used to develop accounts receivable information, to bill you, and, with your consent, to provide information to your insurance company or other third party payer for services provided. We also may use and disclose your medical information to obtain payment from other third parties who may be responsible for such costs, or to bill you directly for services and items under applicable law. The information provided to insurers and other third party payers may include information that identifies you, as well as your diagnosis, dates and type of service, and other information about your condition and treatment, but will be limited to the least amount necessary for the purposes of the disclosure.

• Health Care Operations: Your medical and mental health information may be used and disclosed in connection with our health care operations, including quality improvement activities, training programs, and obtaining legal services. These uses and disclosures are important to ensure that you receive quality care and that our organization is well run. An example of the way in which we may use and disclose your information for our operations would be to evaluate the quality of care you received from us. We may also disclose your information to doctors, nurses and students for review and learning purposes. We maintain safeguards to protect your Protected Health Information against unauthorized access and uses. We may share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. Only necessary information will be used or disclosed.

• Other Permitted and Required by Law Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object:

Your medical/mental health care information may be used or disclosed when I am required or permitted to do so by law or for healthcare oversight. This includes, but is not limited to:

(a) reporting child abuse or neglect;

(b) when court ordered to release information;

(c) when there is a legal duty to warn or to take action regarding imminent danger to others;

(d) when the client is a danger to self or others or gravely disabled;

(e) when a coroner is investigating the client's death; or

(f) to health oversight agencies for oversight activities authorized by law and necessary for the oversight of the health care system, government health care benefit programs, or regulatory compliance;

(g) to prevent or control disease, injury or disability;

(h) to maintain vital records, such as births and deaths:

(i) to notify a person regarding potential exposure to a communicable disease;

(j) to notify a person regarding a potential risk for spreading or contracting a disease or condition;

(k) to report reactions to drugs or problems with products or devices;

(l) to contact public health surveillance, investigation or intervention;

(m) to notify individuals if a product or device they may be using has been recalled;

(n) to notify appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient including domestic violence; however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information; and

(o) to notify your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

Abuse, Neglect and Domestic Violence:

We may disclose your medical information to a government authority if we believe you are a victim of abuse, neglect or domestic violence. If we make such a disclosure, we will inform you of it, unless we think informing you places you at risk of serious harm or if we were to inform your personal representative, is otherwise not in your best interest.

Communicable Diseases:

We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight Activities:

We may disclose your medical information to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs and compliance with civil rights laws.

Lawsuits and Similar Proceedings:

We may use and disclose your medical information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your medical information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement:

We may release medical information if asked to do so by law enforcement officials:

1. Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement per state law;

2. Concerning a death we believe might have resulted from criminal conduct; 3. Regarding criminal conduct at our practice.

4. In response to a warrant, summons, court order, subpoena or similar legal process;

5. To identify/locate a suspect, material witness, fugitive or missing person; and

6. In an emergency, to report a crime (including the locating or victim(s) of the crime, or the description, identity or location of the perpetrator).

Coroners, Medical Examiners, and Funeral Directors:

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We may also release medical information about our patients to funeral directors as necessary to carry out their duties.

Organ and Tissue Donation:

We may use or disclose your medical information to organizations that handle organ and tissue procurement, banking or transplantation.

Serious Threats to Health or Safety:

We may use or disclose your medical information when necessary to reduce or prevent a serious threat to your health and safety or another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Specialized Government Functions:

We may disclose your medical information if you are a member of the U. S. or foreign military forces (including veterans) and if required by the appropriate military command authorities. In addition, we may disclose your medical information to federal and/or state and/or local officials for intelligence and national security activities authorized by law. We also may disclose your medical information to federal officials in order to protect the President, other officials or foreign heads of state or to conduct investigations. Furthermore, we may disclose your medical information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary:

1. For the institution to provide health care services to you;

2. For safety and security of the institution; and

3. To protect your health and safety or the health and safety of other individuals.

Workers' Compensation or Disability Claims:

We may release your medical information for your workers' compensation and disability claims and similar program to appropriate agencies.

• Contacting the Client: You may be contacted to remind you of appointments and to tell you about treatments or other services that might be of benefit to you. If you do not wish to be contacted in this manner, please let Dr. Weiss know in writing.

• Crimes on the premises or observed by the provider: Crimes that are observed by the therapist or the therapist's staff, crimes that are directed toward the therapist or the therapist's staff, or crimes that occur on the premises will be reported to law enforcement.

• Business Associates: Some of the functions of the practice may be provided by contracts with business associates. For example, some of the billing, legal, auditing, and practice management services may be provided by contracting with outside entities to perform those services. In those situations, protected health information will be provided to those contractors as is needed to perform their contracted tasks. Business associates are required to enter into an agreement maintaining the privacy of the protected health information released to them.

• Involuntary Clients: Information regarding clients who are being treated involuntarily, pursuant to law, will be shared with other treatment providers, legal entities, third party payers and others, as necessary to provide the care and management coordination needed.

• Family Members and Others Involved in Your Healthcare: Except for certain minors, incompetent clients, or involuntary clients, protected health information cannot be provided to family members without the client's consent. In situations where family members are present during a discussion with the client, and it can be reasonably inferred from the circumstances that the client does not object, information may be disclosed in the course of the discussion. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care. However, if the client objects, protected health information will not be disclosed.

• Emergencies: In life threatening emergencies the practice will disclose information necessary to avoid serious harm or death. Uses and Disclosures Requiring Your Written Authorization or Release of Information Except as described above, or as permitted by law, other uses and disclosures of your medical and mental health information will be made only with your written authorization to release the information. When you sign a written authorization, you may later revoke the authorization in writing as provided by law. However, that revocation may not be effective for actions already taken under the original authorization.

- Communication Barriers We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances. Treatment Alternatives/Health-Related We may use and disclose your medical information to inform you of treatment alternatives and/or health-related benefits and services that may be of interest to you.

Disclosure:

We shall only disclose protected health information as permitted by law or with your permission. In addition, we shall make every effort to prevent unintentional disclosure although the regulations consider

such disclosure legal. When necessary for your care or treatment, our operations and related activities, we use protected health information internally and may disclose such information to other healthcare providers (doctors, dentists, hospitals, nursing homes or other covered healthcare providers, insurers, third party administrators, payers, and others who may be financially responsible for payment for services and benefits you receive, vendors, consultants, government authorities and other surveying entities and their respective agents). These parties are required to keep your protected health information confidential, as provided by law. Some examples of what we do with the information we collect and the reasons:

1. Administration of health benefits policies or contracts which may involve claims payment and management; utilization review and Management; medical necessity review; coordination of care and benefits;

2. Quality assessment and improvement activities, such as peer review and credentialing of participating providers, program development and accreditation;

3. Performance measurement and outcomes assessment and health claims analysis;

4. Data and Information systems management; and

5. Performing regulatory compliance/reporting, and public health activities; responding to requests for information from regulatory authorities, responding to government agency or court subpoenas as required by law, reporting suspected or actual fraud or other criminal activity; conducting litigation, arbitration and performing third-party liability, subrogation and related activities.

Psychotherapy Process Notes:

Psychotherapy process notes are notes written by your therapist during or after your psychotherapy session, which may contain detailed information about what was discussed during therapy. Psychotherapy process notes are maintained separate from your mental health record. These are paper files that are kept in locked filing cabinets to prevent unauthorized individuals from accessing them. Psychotherapy process notes are not necessarily generated for every therapy session. There may be psychotherapy process notes for none, some, or all of your therapy visits (at the discretion of your therapist). You may request that your therapist not store psychotherapy process notes for you, but this may hinder your therapist's ability to work as effectively in treatment with you. These notes will be used only by your therapist and disclosure will occur only under these circumstances:

(a) you specifically authorize their use or disclosure in a written authorization;

(b) the therapist who wrote the notes uses them for your treatment;

(c) if you bring a legal action, and we have to defend ourselves; or

(d) certain limited circumstances defined by the law. Psychotherapy Visit Notes:

Psychotherapy visit notes are not the same as psychotherapy process notes. Psychotherapy visit notes are summaries of what was discussed during therapy and include far less detail than process notes.

Psychotherapy visit notes are included in your mental health record and are stored in your electronic health record, which is kept on a cloud-based electronic medical record. Release of psychotherapy visit notes will still require special permission in writing except in the following circumstances:

(a) if you were to bring legal action, and we needed to defend ourselves;

(b) release is needed for healthcare operations or billing purposes; or

(c) in certain other limited circumstances defined by the law.

In some cases, the psychotherapy visit notes may be incorporated into a combined medication and psychotherapy visit note. In cases of combined medication and psychotherapy visit notes, if you authorize release of your medical record but do not want to authorize release of your psychotherapy visit notes, we will send a modified form of your combined medication and psychotherapy notes with information about the content of the psychotherapy session redacted.

YOUR RIGHTS AS A CLIENT Additional Restrictions: You have the right to request additional restrictions on the use or disclosure of your medical/mental health information. However, the clinician does not have to agree to that request, and there are certain limits to any restriction, which will be provided to you at the time of your request. Ask your clinician for the Request Form.

Alternative Means of Receiving Confidential Communications: You have the right to request that you receive communications from the practice by alternative means or at alternative locations. For example, you may request that bills and other correspondence be sent to an address other than your home address. Ask your clinician for the Request Form. Access to Protected Health Information: You have the right to inspect and obtain a copy of your protected health information in the mental health and billing record. If it is thought that access to your mental health records would harm you, your access may be restricted. Psychotherapy process notes are for the use of your therapist only, and generally are not released except as required by law. Ask your clinician for the Request Form and the appeal process.

Amendment of Your Record: You have the right to request an amendment or correction to your protected health information. If the clinician agrees that the amendment or correction is appropriate, the Practice will ensure the amendment or correction is attached to the record. An appeal process is available if the clinician determines the record is accurate and complete as is. Ask your clinician for the Request Form and the appeal process available to you.

Accounting of Disclosures: You have the right to receive an accounting of certain disclosures the practice has made regarding your protected health information. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you, disclosures authorized by you, or disclosures made prior to April 14, 2003. Other exceptions will be provided to you, should you request an accounting. Ask your clinician for the Request Form.

Right to Revoke Consent or Authorization: You have the right to revoke your consent or authorization to use or disclose your medical/mental health information, except for action that has already taken place under your consent or authorization.

Right to Provide an Authorization for other Uses and Disclosures: We shall make a good faith effort to obtain your written authorization for uses and disclosures that are not identified by this notice or are not

permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your medical information may be revoked at any time in writing by sending a written, signed and dated request to the Privacy Officer. After you revoke your authorization, we will no longer use or disclose your medical information for the reasons described in the authorization. Of course, we are unable to take back any disclosures that we have already made with your permission. Please note that we are required to retain records of your care.

Copy of this Notice: You have a right to obtain a copy of this Notice upon request. The Practice is required to abide by the terms of this Notice, or any amended Notice that may follow. The Practice reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all protected health information that it maintains.

Changes to this Notice: The terms of this notice apply to all records containing your medical information that are created or retained by us. We reserve the right to revise, change or amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all of the information that we already have about you, as well as any medical information that we may receive, create, or maintain in the future. When changes are made, the revised Notice will be posted at the Practice's office and copies will be available upon request.

If you believe the Practice has violated your privacy rights, you may file a complaint with the Practice by submitting it to Dr. Weiss. You also have the right to complain to the United States Secretary of Health and Human Services by sending your complaint to the Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 515F, HHH Bldg., Washington, D.C. 20201. It is the policy of the Practice that there will be no retaliation for your filing of such a complaint.

TREATMENT CONSENT FORM

SERVICES OFFERED

PSYCHOTHERAPY

Psychotherapy, or talk-therapy, is a powerful treatment for many mental complaints. It offers benefits of improved interpersonal relationships, stress reduction, and a deeper insight into one's own life, values, goals, and development. It requires a great deal of motivation, discipline and work on both parties for a therapeutic relationship to be an effective one. Clients will have varying success depending on the severity of their complaints, their capacity for introspection, and their motivation to apply what is learned outside of sessions.

Clients should be aware that the process of psychotherapy may bring about unpleasant memories, feelings, and sensations such as guilt, anxiety, anger, or sadness, especially in its initial phases. It is not uncommon for these feelings to have an impact on current relationships you may have. If this occurs, it is very important to address these issues in session. Usually these unpleasant sensations are short lived.

At your initial visit, I will conduct a thorough review of your current complaints and of your background. By the end of the initial visit I will offer my preliminary impressions, and we will discuss your treatment options. Sometimes, psychotherapy alone will suffice. Often times, however, a combination of psychotherapy and medication management is optimal (see below). One of the most important curative aspects of a therapeutic relationship is the goodness-of-fit between therapist and client, so, the initial visit is also your opportunity to determine for yourself if I am the right therapist for you. If you feel that I am not well matched to your needs, I would be happy to provide you referrals to other mental health professionals.

MEDICATION

Medications may be indicated when your mental symptoms are not responsive to psychotherapy alone. When a mental illness markedly impacts your ability to work, maintain interpersonal relationships, or properly care for your basic needs, medication may offer much needed relief. If it is agreed that medications are indicated, I will discuss with you all of the medication options that are available to treat your current condition. I will present information in language that you can understand. You will learn how the medication works, its dosage, and frequency, its expected benefits, possible side effects, drug interactions, and any withdrawal effects you may experience if you stop taking the medication abruptly. By the end of the discussion you will have all the information you need to make a rational decision as to which medication is right for you.

You may already be receiving psychotherapy from another therapist, and are referred to me for medication management. In this case I will make a strong effort to coordinate care with your therapist (with your consent, of course). I believe communication between mental health professionals is key to providing effective care.

Not everyone is a good candidate for medication therapy. Such therapy requires strict adherence to dosage, and frequency, close follow-up, and sometimes regular blood tests. Your ability to adhere to medication treatment will be taken into consideration in making the decision to start such therapy. Overall, I am a strong proponent of the bio-psycho-social model of medical treatment. Treatment that considers your biological status, genetics, your psychological development, and social issues together will yield the best chance for success in achieving your goals.

FREQUENCY AND DURATION OF VISITS

At your initial visit, we will decide together the structure of your treatment. If your symptoms improve, follow-up visits may be spaced out at longer intervals. For clients on maintenance therapy, follow-up visits can be held at three-month intervals or as clinically appropriate. If you are to undertake psychotherapy, weekly 50-minute sessions will provide the best results.

FEES

You will be given a separate form with information about the fees for the services provided at this practice.

CANCELLATIONS AND NO-SHOWS

If you must cancel or reschedule an appointment, I require at least 24-hour notice (weekends not included). If your appointment is on a Monday, the cancellation must be made by the same hour on the preceding Friday. Cancellations that occur with less than 24-hour notice or failure to show to an appointment will be charged a **no show fee**

PAYMENTS

I will expect payment at the beginning of each session, unless we have agreed on other arrangements. I accept personal check, and major credit cards. Checks should be made payable to “Tamara Weiss, MD, LLC.” If payment is 60 days past due, I reserve the right to utilize legal resources such as collection agencies or small claims court in order to obtain payment for my services.

MY PRACTICE

While I share an office with other mental health professionals, I am in no way part of a group practice. My medical records are kept secure, and separate from theirs. No person operating

in my office suite will have access to your records without your written consent. I am fully responsible for the services I provide you.

If you do see one of my office-mates for psychotherapy, or if I refer you to another community therapist/physician, we may find it helpful to collaborate and coordinate your care, and this will require your written consent. Any clinician to whom I refer you will be responsible for the care they provide to you.

CONTACT INFORMATION

My voice mail at 678-996-5901 is the best way to contact me outside the office. If you need to reach me about an urgent matter, you can call 678-996-5904. Please note that I may be with a client, but will make every effort to address your issue as soon as possible. For non urgent matters, please allow 24 business hours for a response. Messages left late in the day, on weekends or holidays, may not be returned until the next business day. If you or someone close to you is in immediate danger, please call 9-1-1 or proceed to the nearest emergency room.

If you choose to contact me via e-mail, please be aware that e-mail is not a secure means of communicating sensitive mental health information. You may wish instead to contact me through the patient portal, which is a secure method of communication of confidential information. I do not always check my e-mail or portal messages regularly (especially on nights and weekends) so it is not an appropriate way of contacting me in an emergency.

Drug History Consent Form

CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program ePrescribing is way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. The ePrescribe Program also includes:

- Formulary and benefit transactions - Gives the health care provider information about which drugs are covered by your drug benefit plan.
- Fill status notification - Allows the health care provider to receive an electronic notice from the pharmacy telling them if your prescription has been picked up, not picked up, or partially filled.
- Medication history transactions - Provides the health care provider with information about your current and past prescriptions.

This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicative therapy. The medication history information would include medications prescribed by other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions, venereal diseases/sexually transmitted diseases, abortion(s), rape/sexual assault, substance (drug and alcohol) abuse, genetic diseases, and HIV/AIDS. As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.

Consent

By signing this consent form you are agreeing that your provider at the practice may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it. This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation. Understanding all of the above, I hereby provide informed consent to the practice to enroll me in this ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

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