

SURGICAL ASSOCIATES OF COLLIN COUNTY
Sheetal M. Patel, M.D.

PATIENT PHYSICIAN LIST

PATIENT NAME: _____ **DATE:** _____

Please provide the names and contact information of the doctors and specialists you have visited and have participated in your care over the last five years.

Primary Care Physician

Name: _____ **City:** _____

Phone: _____ **Fax:** _____

Cardiology:

Name: _____ **City:** _____

Phone: _____ **Fax:** _____

Pulmonary:

Name: _____ **City:** _____

Phone: _____ **Fax:** _____

Gastroenterdology:

Name: _____ **City:** _____

Phone: _____ **Fax:** _____

Endocrinology:

Name: _____ **City:** _____

Phone: _____ **Fax:** _____

Hematology:

Name: _____ **City:** _____

Phone: _____ **Fax:** _____

Gynecologist:

Name: _____ **City:** _____

Phone: _____ **Fax:** _____

Other:

Name: _____ **City:** _____

Phone: _____ **Fax:** _____

Patient Signature

Date:

Authorization to Disclose Health Information

I hereby authorize the use or disclosure of information from the medical records of:

Patient Name Date of Birth Social Security Number

I authorize the following individual or organization to disclose the above named individual's health information:

PHONE: _____ FAX: _____

This information may be disclosed to and used by the following individual or organization:

Sheetal M. Patel, M.D. PHONE: (972) 596-5225 FAX: (972) 596-2684

Please release the following: Medical Weight History –2020, 2019, 2018, 2017, 2016 and 2015
Please send 1 complete visit note for each year patient was seen in your office.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency (AIDS), or human immunodeficiency (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Initials required: _____

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____

If I fail to specify and expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-closure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Joyce Snell, Privacy Officer for Surgical Specialists of Plano at 972-596-5225.

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative Signs Above)

Witness

Complete only if information is to be released directly to patient:

I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Surgical Specialist of Plano liable of any misinterpretation of information in my medical record as a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative

Date

Relationship to Patient (If Legal Representative Sign Above)

Witness

Date request completed _____ # of pages copied: _____ Staff Initials _____

SURGICAL ASSOCIATES OF COLLIN COUNTY

ALAN LONDON, MD SHEETAL PATEL, MD

Notice of Privacy 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.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof. This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time. You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect a copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information, to provide you with this Notice of Privacy Practices, and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

I will allow messages to be left on my answering machine or voice mail: Y N

Persons authorized to discuss Medical Information:

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Office Manager or Privacy Officer to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices went into effect April 14, 2003.

E-PRESCRIPTIONS - Do we have your consent to download the medication list from your pharmacy?

Y N

Patient Name (print): _____

Patient Signature: _____ Date: _____

(Or Legal Guardian)

For No Expiration Please Initial: _____