AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information, about you.

Patient's Name:_____ Date of Birth:_____

Phone # _____ Social Security: _____

I request and authorize (Previous Provider) _____

(address,ph,fax) _____

To Release healthcare information of the patient named above to:

☐ Name: _____ or ☒ Michael K. Lloyd, M.D. Inc.
460 Greenfield Ave. Ste.#3
Address:_____ Hanford, CA 93230
Ph: 559-584-5770
Fax: 888-774-0477

This request & authorization applies to:

a. ☒ All health information pertaining to my medical history, mental or physical condition – OR

☐ Only the following records or types of health information. Include date(s) of treatment:

_____

b. I specifically authorize release of the following information (check as appropriate):
☐ Mental health treatment ☐ HIV test results ☐ Alcohol/drug treatment information

A separate authorization is required to authorize the disclosure or use of psychotherapy notes.

Purpose of requested use or disclosure: Patient request **( )**; OR **( )** other:
__Continuity of Care_____

Expiration date: _____ (This authorization will expire in 6 months unless otherwise indicated).

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address:
  Michael K. Lloyd, M.D., 460 Greenfield Ave. Ste #3, Hanford, CA 93230
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to and will receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by Federal confidentiality law (HIPAA).

Signature: _____ Print: _____ Date:_____
(Patient/representative/spouse/financially responsible party)

(If signed by someone other than the patient, state your legal relationship to the patient)

NOTICE OF PRIVACY PRACTICES

To The Patients of Michael K. Lloyd, M.D. : This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:
1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: Michael K. Lloyd, M.D. 460 Greenfield Ave. Ste# 3 , Hanford, CA 93230. (559) 584-5770. Attention Administrator or Safety Officer.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete. To request an amendment, your request must be made in writing and submitted to: Michael K. Lloyd, M.D. 460 Greenfield Ave. Ste# 3 , Hanford, CA 93230. (559) 584-5770. Attention Administrator or Safety Officer. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact : Michael K. Lloyd, M.D. 460 Greenfield Ave. Ste# 3 , Hanford, CA 93230. (559) 584-5770. Attention Administrator or Safety Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact : Michael K. Lloyd, M.D. 460 Greenfield Ave. Ste# 3 , Hanford, CA 93230. (559) 584-5770. Attention Administrator or Safety Officer.

I consent for _____, _____, _____ to receive
First, Last Name ***Relationship; husband, wife, child etc.*** ***DOB***
Verbal/written or any information regarding my health records.

Name of Patient: _____ Date: _____

Patient's Signature: _____

CONSENT FOR TREATMENT & FINANCIAL DISCLOSURE

Michael K. Lloyd, M.D. 460 Greenfield Ave. Ste# 3 , Hanford, CA 93230. (559) 584-5770.

The signature of the responsible party listed below hereby acknowledges and agrees to the following:

1. I hereby do voluntarily consent to such care including routine procedures and other treatment by Michael K. Lloyd, M.D. Inc. professionals and their assistants, appointees, or consultants as is necessary in their judgment.

2. I am aware that the practices of medicine, surgery and other health disciplines do not constitute exact sciences and I acknowledge that no guarantees have been made to me as to the result of treatments of examination by Michael K. Lloyd, M.D. Inc. If I don't fully understand a procedure or its risks, consequences, and alternate methods of treatment, I have the right to question the appropriate health care professionals.

3. I understand that Michael K. Lloyd, M.D. Inc. shall not be responsible or liable for the loss of/or damage to any personal property.

4. I authorize the release to any party responsible for such information from my records as is required in order for the group and all entities providing services to obtain payment. This I ncludes records of alcohol and drug abuse and/or treatment, records of psychological services and social services, including communications made by the patient to a physician, social worker, or psychologist. This authorization shall be effective only so long as necessary to obtain payment or reimbursement and will end when payment or reimbursement is received.

5. The responsible party agrees to pay any balance due after the insurance company processes the claim, within thirty (30) days of notice from our billing service, regardless of the reason for the balance due (for example, deductible amounts, co-insurance, or denial of benefits by the insurance carrier).

6. The responsible party agrees that if any balance due Michael K. Lloyd, M.D. Inc. not paid in a timely manner, then attorneys' fees, collection agency costs and any related fees to Michael K. Lloyd, M.D. Inc. will be added to the balance due.

I certify that I have read this statement and have had an opportunity to review with the group personnel any questions I may have had regarding the same.

Today's Date: _____

Patient's Printed Name: _____

Responsible Party's
Printed Name (if different): _____

Responsible Party's
Signature: _____

EMERGENCY CONTACT

Please contact the following person when unable to reach me:

Name: _____ **Phone:** _____

MICHAEL K. LLOYD MD, INC - Health History CHILD

Child Name: _____
Date: _____
Phone: _____

FAMILY MEMBERS
Father's name: _____
Mother name: _____
Sibling's names & ages: _____
_____
_____
_____
_____

PERSONAL HISTORY
Is the Child Yours by: *BIRTH ADOPTION STEP CHILD OTHER*
Ethnic Background: _____

DELIVERY/PREGNANCY/BIRTH HISTORY
Date & Place of Birth: _____
Delivery by: *Vaginal Delivery* *Caesarean (why):* _____
How many weeks pregnant when delivered? _____
Birth Weight _____ Length _____
Any Medical Problems during pregnancy? *NONE*
_____
Was your child breastfed? *NO* *YES (how long):* _____
Any feeding or dietary problems? *NO* *YES*
*(specify):*_____
Recreation / Play / Exercise: _____
Sleep: Avg Hrs per night: _____
Naps (number & length): _____
Who takes care of the child during the day?
Parent Family member Babysitter Daycare School

ALLERGIES TO MEDICATIONS *NO KNOWN ALLERGIES*

Substance / Medication	Reaction

HOSPITALIZATIONS/ SURGERIES / MAJOR INJURIES

Year	Hospital	Describe Hospitalization or Surgery

Has your child had: *Chickenpox Measles Mumps Rubella Meningitis Tuberculosis (TB)*

Date of Last:
Tetanus Shot: _____
Flu Shot: _____
Gardasil: _____

FAMILY HEALTH HISTORY
Check (√) if your child or blood relatives have ever had any of the following (Cross out if nobody has ever had):

	Disease	Family	Details
Child	Alcohol/Drug dependency		
	Anemia		
	Anxiety or depression		
	Asthma/ Lung Disease		
	Blood Clots		
	Blood Transfusions		
	Breast disease or Cancer		
	Cancer (any other)		
	Diabetes		
	Genetic disease or Birth defects		
	Heart problems		
	Hepatitis		
	High Blood Pressure		
	HIV		
	Kidney disease		
	Liver disease		
	Lupus or Arthritis disease		
	Migraines		
	Neurological disease		
	Pap smear ever abnormal		
	Sexual infections (Gonorrhea, Chlamydia, Herpes, Syphilis)		
	Seizures		
	Stomach problems		
	Stroke		
	Thyroid disease		
	Tuberculosis		
	Any Other disease		

PLEASE BRING CHILD'S IMMUNIZATION RECORD
AS WELL AS ALL MEDICATIONS GIVEN TO YOUR CHILD
TO ALL APPOINTMENTS (Including all over the counter medications)

SPIRITUAL ASSESSMENT (optional)
Do you believe in God or a higher power? *YES* *NO*

Would you appreciate prayer for: *You* *Your Family* *Your Health*
Other: _____

YES – during office visit *YES – while I'm not present.*

NO - Not at this time. *Maybe*

Comments: