HIPAA WAIVER OF AUTHORIZATION (Form HIPPA-EHS-20v1)

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This is to confirm that EHS is willing to collaborate with other medical practitioners, medical insurance entities, and government entities regarding a patient's protected medical record and history if, and when, it is deemed necessary by any, or all, of the aforementioned entities to ensure the appropriate administration of your individual healthcare needs and/or continual adherence to federal and state mandated lawful practices. I understand records belong to EHS, but that the information in them is the patient's information. EHS is required by law to keep information about you private, to give you this Notice about our privacy practices, and to follow the practices outlined in this Notice.

EHS is aware that the information shared involves the use and/or disclosure of Protected Health Information (PHI) for varying purposes as deemed necessary and appropriate by either our practitioner's medical judgement and knowledge, another medical practitioner's medical judgement and knowledge, medical insurance requirements, and/or government entities without the explicit circumstantial authorization from the patient.

EHS is also aware that we must provide to our patients, upon request, an accounting of disclosures of their PHI under a waiver of authorization, unless otherwise mandated by law, as well as a copy of the HIPAA Notice of Privacy Practices. I am aware that I can view EHS' HIPPA form via an online platform. I accept EHS' online HIPPA form as fulfillment of EHS' responsibility to provide me a copy of HIPAA Notice of Privacy Practices. I, as a patient of EHS, understand that this information will be provided in printed form only if I specifically request a printed/physical copy of it. I acknowledge that I have either received a physical copy of these waivers/forms or that I have declined to receive physical copies of them.

Our practice will use and disclose your individually identifiable health information when required to do so by federal, state or local law concerning public health risks, health oversight risks, inspections, investigations, lawsuits and similar proceedings, and law enforcement requests, threats to health and safety to you or others, if you are a member of a military force or for National Security reasons.

Privacy of Electronic Prescriptions:

1. Privacy of electronically submitted prescriptions falls under HIPAA regulations based upon the recent e-prescribing final rule.
2. Authorization to access this data is role-based given the sensitivity associated with certain medications.

3. All treating health care providers have access to Controlled Substances, to reduce the incidences of drug-drug interactions, drug-condition contraindications, patient safety, etc.
4. I, a patient of EHS or a legal guardian/authorizing agent of a EHS patient, approve the submission of electronic prescription(s) and necessary accompanying healthcare information to healthcare providers, home health companies, rehabilitation companies, government entities, and/or my indicated pharmacy of choice. I agree to permit EHS to review any governmental based controlled substance database regarding any prescriptions I may have received from anyone anywhere at any time. I furthermore agree to permit EHS to directly contact my PCP, my medical subspecialist, and/or my pharmacies to gain information regarding me being prescribed any controlled substances.
5. I, a patient of EHS or a legal guardian/authorizing agent of a EHS patient, approve the submission of PHI and necessary accompanying information via phone conversation, email, and voicemail, provided appropriate identification measures are taken for patient verification.

If it is in our practitioner's better medical judgement to disclose your individually identifiable health information, this letter confirms a waiver of authorization for EHS to collaborate with and share your individually identifiable health information with other medical practitioners, home health companies, rehabilitation companies, government entities, and/or medical insurance entities, unless otherwise mandated by law, without your specific circumstantial consent, to ensure the patient's physical well-being and the administration of appropriate health care needs.

By accepting the Terms & Conditions for Service (Form TCS-EHS-20v1) with EHS, I, a patient of EHS or a legal guardian/authorizing agent of a EHS patient, authorize EHS to share my individually identifiable health information, or that of the EHS patient in the event these Terms & Conditions are being authorized by a legal guardian/authorizing agent of a EHS patient, with health-care practitioners, home health companies, rehabilitation companies, government entities, and/or medical insurance facilities as needed or as seen appropriate in our clinician's better medical judgement, without explicit circumstantial approval from me, unless otherwise mandated by law.