Thomas R. Traylor, M.D.
Patient Consent Form for Care and Treatment
And HIPAA Authorization and Notification

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. Effective April 14, 2003, Federal Regulations required healthcare providers not to give any kind of information to any person other than you, the patient, without your prior permission. This includes not giving information to your spouse, parent, other household members, relatives, etc., even when they call or come in to our office on your behalf or at your request unless you have given us permission to talk to them. I acknowledge that I have been offered a copy of the HIPAA law. I understand I have the 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 Privacy Officer.

If I fail to specify an expiration date, this authorization will expire one year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure 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 redisclosure and the information may not be protected by federal confidentiality rules. I understand that Thomas R Traylor, MD, PC has the right to change its' Notice of Privacy Practices from time to time and I may at any time contact them for a current copy.

By signing this authorization I understand that my information will be disclosed for the following

- For treatment…we may disclose medical information about you to multi healthcare providers who may be involved in your healthcare. At times this information may need to be faxed or mailed.
- For payment…we may use and disclose medical information about you to hospitals and to obtain payment from third party payers.
- For general healthcare operations.
- Appointment reminders and individuals involved in your care including nurse calls.
- Gives permission to leave messages on answering machines.

Please tell us how we may contact you and to whom we may disclose your health information.
Home Phone #________________, Work Phone #_________________,
Cell Phone #________________, Alternate Phone #_________________
You may speak with my (Spouse), (Parents), or (Person) listed below about my medical condition(s) and treatment. ___________________,_______________,________________

_______________________________________ _________________________
Signature of Patient or Legal Representative Date Authorization Executed

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Patient Name (please print)

Renewal Dates:

____________________ _____________________ _________________
____________________ _____________________ _________________
____________________ _____________________ _________________