HIPAA Release Form

HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L 104-191), 42 U.S.C. Section 1320d, et seq, and regulations promulgated there under, as amended from time to time (collectively referred to as "HIPAA".)

This authorization affects your rights in the privacy of your personal healthcare information (PHI.) Please read it carefully before signing.

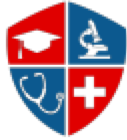
YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization, you acknowledge and agree that Dr. Scott W. Lamprecht, APRN, FNP-BC, RN may use or disclose personal health information for the purpose(s) of treatment and consultation. By signing this authorization, you agree that Dr. Scott W. Lamprecht, APRN, FNP-BC, RN, may disclose your personal health care information to ______________________________- for treatment and consultation purposes.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand HIPAA Privacy Notice containing a complete description of your rights, and the permitted rights, and the permitted rights and disclosures, under HIPAA. While Wellness Education Centers of Nevada has reserved the right to change the terms of its Privacy Notices, copies of the Privacy Notice as amended are available from the Las Vegas Medical Facility's office or by sending a written request with return address to 8410 N Rafael Rivera Way, Las Vegas, NV 89113.

In accordance with your rights under, and subject to certain restrictions imposed by, HIPAA, you may inspect or copy your PHI in the designated record set maintained by Wellness Education Centers of Nevada for as long as the PHI is maintained in the designated record set. You have the right to revoke this authorization, in writing, at any time, except to the except to the extent Las Vegas Medical Facility has acted in reliance on it. A revocation is effective upon receipt by of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above. This authorization shall expire upon the earlier occurrence of: a) revocation, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA,(c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion Las Vegas Medical Facility, or (d) six years from the dated years from the dated this authorization was executed.

By signing this authorization, you acknowledge and agree that any information used by disclosed pursuant to this authorization could be at risk for redisclosure by the recipient and no longer protected under HIPAA.



Las Vegas College
MEDICAL FACILITY

Las Vegas Medical Facility will provide ____ with a copy of this signed authorization.

Acknowledged and agreed to by:

Signed: ____

Print Name: ____

Address: ____

____

Date: ______________________________

Las Vegas College
MEDICAL FACILITY

WELCOME

PATIENT INFORMATION (Please circle responses when needed)

Today's Date:___________________________

LAST NAME__________________________________

FIRST NAME ____________________________ MI___________

SEX Male Female Other _____________

DOB____________________AGE___________

SSN:___________________________________

ADDRESS

____

CITY_____________________________________

STATE_______________ZIP__________________

Mobile Phone(_____)______________________

Home Phone (_____) _______________________

Best time/place to reach you?

____

Permission to Leave Message Yes No

IN CASE OF EMERGENCY CONTACT

NAME ___________________________________

PHONE #______________________ ALT#__________________

RELATIONSHIP ____________________________

EMAIL:___________________________________

MARRIED WIDOWED SINGLE MINOR

SEPARATED DIVORCED PARTNERED

OCCUPATION______________________________

PATIENT EMPLOYER/SCHOOL

____

EMPLOYER/SCHOOL ADDRESS

CITY_____________________________________

STATE_______________ZIP__________________

EMPLOYER/SCHOOL PHONE (______)___________________________

SPOUSE'S NAME

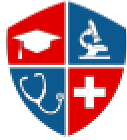
____

DOB_____________________ SSN_______________________________

SPOUSE'S EMPLOYER_______________________________

Whom may we thank for referring you?

____



Las Vegas College
MEDICAL FACILITY

INSURANCE

Who is responsible for this account?

____

Relationship to Patient__________________________________

Insurance Co.

____

Group# ________________________________

Member ID#_____________________________

Is patient covered by an additional insurance?
Yes No

Subscriber's Name

____

DOB_________________
SSN___________________________

Relationship to Patient__________________________________

Insurance Co____

Insurance ID___________________________
Group#________________________________

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

____

(Name of Insurance Company(ies)

and assign directly to DR. SCOTT LAMPRECHT, APRN, FNP-BC, RN all insurances benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all submissions.

DR. SCOTT LAMPRECHT, APRN, FNP-BC, RN may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE / MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, made either to me or on my behalf to Wellness Education Centers of Nevada for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signed:__________________________________
(Signature of Beneficiary, Guardian or Personal Representative)

Print:__________________________________

(Print name of Beneficiary, Guardian or Personal Representative)

Date Signed: ____________________________

Relationship to Beneficiary_________________

FAMILY HISTORY

Date of last physical exam

____

What is the reason for your visit?

____

____

Father   Alive   Deceased

Present health: Good   Fair   Poor

Illnesses__________________________________

Mother   Alive   Deceased

Present health: Good   Fair   Poor

Illnesses__________________________________

Spouse   Alive   Deceased

Present health: Good   Fair   Poor

Illnesses__________________________________

Siblings   No. Alive

Present health: Good   Fair   Poor

Illnesses__________________________________

Children   Alive   Deceased

Present health: Good   Fair   Poor

Illnesses__________________________________

Circle Illnesses which have occurred in any of your blood relatives:

Diabetes   Cancer   Bleeding tendency

Kidney Disease   Allergy   Tuberculosis

Heart disease   Stroke   High Blood pressure

Neurologic Disorders

5. HEALTH HISTORY All information is strictly confidential

Describe serious illnesses of operations

____

____

Circle symptoms you currently have or have had in the past five years.

GENERAL

Chills

Depression/ Nervousness

Dizziness/ Fainting

Fever

Forgetfulness

Headache

Loss of Sleep

Loss of Weight

Numbness

Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:

Arms   Back   Hips   Legs   Feet   Neck

Hands   Shoulders

Genito-Urinary

Blood in urine   Frequent urination

Lack of bladder control   Painful urination

Circle symptoms you currently have or have had in the past five years.

GASTROINTESTINAL

Poor Appetite

Bloating

Bowel changes

Constipation

Diarrhea

Excessive thirst

Gas

Hemorrhoids

Indigestion

Nausea

Rectal bleeding

Stomach pain

Vomiting

Vomiting blood

CARDIOVASCULAR

Chest pain

High/Low blood pressure

Irregular/ Rapid heartbeat

Poor circulation

Swelling of ankles feet hands

Varicose veins

EYE, EAR, NOSE, THROAT

Bleeding gums

Blurred vision

Crossed eyes

Difficulty swallowing

Double vision

Earache/ Ear discharge

Hay Fever

Hoarseness

Loss of hearing

Nose bleeds

Persistent cough

Ringing in ears

Sinus problems

Vision- Flashes/ Halos

SKIN

Bruise easily

Hives

Itching/Rash

Change in moles

Scars

Sore that won’t heal

Females only

Abnormal Pap smear

Bleeding between periods

Breast lump

Extreme menstrual pain

Hot flashes

Nipple discharge

Painful intercourse

Vaginal discharge

Have you had a mammogram? YES NO

When:_______________

Date of last menstrual period:________________

Date of last Pap Smear

____

Are you pregnant? ___________

Number of children?__________

Delivery:

Vaginal: #___________

C-section: #__________

Males only

Erection difficulties Lump in testicles

Penis discharge Sore(s) on penis

Other

Circle if you ever had any of the following:

AIDS	Emphysema	Measles	Scarlet Fever
Appendicitis	Epilepsy	Migraine Headaches	Stroke
Arthritis	Glaucoma	Multiple Sclerosis	STIs/STDs
Asthma	Heart disease	Mumps	Substance Abuse
Bleeding disorders	Hepatitis	Pacemaker	Thyroid Problems
Breast lump	Herpes	Pneumonia	Tuberculosis
Cancer	High Cholesterol	Polio	Ulcers
Cataracts	HIV Positive	Prostate Problem	
Chicken Pox	Kidney Disease	Rheumatic Fever	
Diabetes	Liver disease		

Medications/Allergies

List medications you are currently taking ________________________

____

____

Pharmacy Name ____

Phone (______)____

List allergies to medications or substances _______________________

____

Health Habits

Circle which you use or if exposed at work

Caffeine ___________ Stress

Illicit drugs________ Heavy Lifting

Tobacco ___________ Hazardous Substances

CBD ______________ Marijuana__________ _______________

Other_____________

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signed: ____Date:_______________

(Signature of Patient, Parent, Guardian or Personal Representative)

Printed:____Date:_______________

(Print name of Patient, Parent, Guardian or Personal Representative)

INFORMED CONSENT

DR. SCOTT W. LAMPRECHT, APRN, FNP-BC, RN

DATE___________________

Patient's Name____

Instructions: This document relates to your informed consent for care.

Please read carefully before signing.

General: I, the below-signed patient/individuals, have read this document and Care Plan in their entirety and understand the potential benefits and risks of the Care which you are recommending. I understand that there may be other forms of care which I may wish or need to seek provided by other health care practitioners. I also understand that there may be significant risks of not seeking any care for my condition. I understand that while the Care Plan lists you as the "Rendering Provider" at any moment. Other associates or staff in your office with appropriate scopes of practice and training may need to provide the recommended care based on facts which are not necessarily with anyone's ability to predict. You have made it clear that every health care practitioner who is licensed under state law may have different scopes of practice relating diagnosis and treatment. I do not expect you to be able to anticipate and explain all risks and complications, or forms of treatment, and I wish to rely on you to exercise judgement within your scope of practice during the Care Plan which you feel at the time based upon the facts known. I understand that in rare cases, underlying physical defects, deformities or pathologies may render me susceptible to injury. It is my responsibility to make known before and throughout the Care whether I am suffering from any latent pathological defects, illnesses, or deformities I may be experiencing.

Definitions: "You" and "office" refer to any provider who renders care to me at the location above. "Care" includes all care outlined in my Care Plan as well; as any other care I receive from you in the future, including care related to other conditions.

Possible Risks of the "Care; Alternatives: As with any healthcare procedure, I understand that there are certain complications, which may arise during the specified procedure being administered. I acknowledge that I have discussed and understand possible complications that may arise during the procedure.

Patient's Consent: I have thoroughly discussed and reviewed my recommended Care with you, as well as your examination, diagnoses, and thoughts regarding my condition, and all the information in this Informed Consent. I have had ample opportunity to explore other potential forms of care, have asked you all the questions that I have, and have no additional questions. I voluntarily and knowingly elect to receive the recommended care.

Patient's Name:____

Patient's Signature: ____

Date of Signature: ____

Name of Parent/Guardian/Authorized representative: _____________________________________

Signature: ____

Date of Signature: ______________________________