Iriamar Vélez Quiñones, MD

Patient Authorization for Treatment

Patient Name: _____

Date of Birth: _____

READ THIS DOCUMENT CAREFULLY. INITIAL EACH PAGE IN THE MARGIN OF THE DOCUMENT.

Authorization for Treatment

By this document, I, the undersigned, authorize the medical staff of the office of Dr. Iriamar Vélez Quiñones to provide medical care to myself or to the aforementioned patient, if I execute this document as a parent or guardian. I understand that my medical record will include information related to my appointments with the healthcare providers in the office. I, being aware that I am suffering from a condition that requires medical diagnosis and treatment, hereby voluntarily authorize all diagnostic procedures (laboratories, X-rays, etc.) and medical treatment deemed necessary at the discretion of Dr. Iriamar Vélez Quiñones. I understand that the practice of medicine is not an exact science and that no guarantee has been offered regarding the outcome of tests and/or treatments.

Consent for Electronic Record:

In the Medical Office of Dr. Iriamar Vélez Quiñones, we utilize an electronic information management system. We wish to include your health information in this computerized system. We protect the information in the computerized system by limiting access to those individuals who work directly with you and/or have administrative responsibilities in this organization and/or the entity that provides us with services. Paper forms and computers are stored or located in an area accessible only to those individuals. We require all employees of this office or entity that provide electronic information services and are authorized to access or read information on the computers to commit to maintaining system security and confidentiality of the information. Any person who violates this agreement will be subject to penalties under applicable laws.

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Health Information Exchange (HIE)

Iriamar Vélez Quiñones, MD, also participates in electronic exchanges of health information (HIE) with hospitals and various other healthcare providers. I authorize Iriamar Vélez Quiñones, MD, and the HIEs with which they participate to share my health information, through the HIE networks, for purposes

permitted by law, including my treatment and coordination of my care, with all healthcare providers who are authorized under HIE policies and applicable law to access my information. I understand and accept that information about me that may be shared and accessed through HIE may include information regarding HIV/AIDS status, sexually transmitted diseases, family planning, mental health treatment, genetic test results, substance and alcohol use, and other categories of sensitive health information. I understand that I have the right to "opt-out" of having my information shared through HIE. An HIE brochure is available in the office of Iriamar Vélez Quiñones, MD, and I can request it at any time. I consent to having my health information included in the computerized information system of the Medical Office of Dr. Iriamar Vélez Quiñones.

Authorization to Access Electronic Prescription Records

I authorize Iriamar Vélez Quiñones, MD, and its affiliates to view my external prescription history through electronic prescription services. I understand that the prescription history from other non-affiliated medical providers, healthcare staff, and plans may include prescriptions for several years, including prescriptions to treat HIV, substance abuse, and psychiatric conditions, as applicable. I understand that my prescription history will become part of my medical record with Iriamar Vélez Quiñones, MD.

Authorization for Photographs and Release for Use in Medical Records

I hereby authorize and consent to the taking of photographs by Iriamar Vélez Quiñones, MD, its agents, or employees. I consent to the use and storage of such photographs for identification purposes and as part of my medical history. I hereby release Iriamar Vélez Quiñones, MD, its staff, agents, and employees from any liability related to the creation, storage, and use of such photographs and images for identification purposes and as part of my medical record.

Consent for Use and Disclosure of Health Information for Treatment, Payment, and Health Operations:

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I understand that as part of my health care, Dr. Iriamar Vélez Quiñones originates and maintains health records, detailing my health history, symptoms, test results, examinations, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as: a basis for planning my care and treatment, a means of communication among the many professionals contributing to my care, a source of information for billing my surgical diagnosis to my account, and a means by which a health plan can verify that billed services were provided. It is also a tool for healthcare operations, such as evaluating quality and reviewing competency.

Release and Assignment of Benefits

I directly assign all health insurance benefits to which I am entitled from Medicare, Medicaid, Blue Cross, or any other insurance plan to the providers at Iriamar Vélez Quiñones, MD for services rendered on my behalf. I understand that I am financially responsible for all charges, whether I am insured or not at the time of service, including deductibles, coinsurance, copayments, and out-of-network services that are denied and/or not covered by my health insurance plan. I authorize Iriamar Vélez Quiñones, MD, or any holder of medical information to disclose to Medicare, Medicaid, or Blue Cross, or any insurance company or their authorized agents, any necessary information for this or a related claim.

Authorization for Disclosure of Information

I authorize the office of Dr. Iriamar Vélez Quiñones to disclose any necessary information related to my diagnosis or treatment, or that of the aforementioned patient, for the purpose of processing any claims submitted to my insurance provider on my behalf or on behalf of the patient. A copy of this authorization may be used instead of the original version. I authorize the office of Dr. Iriamar Vélez Quiñones to forward a copy of my medical record or that of the patient to any provider to whom I or the patient may be referred for a consultation. I understand that if I or the aforementioned patient need a referral to community services, including the Department of Health and the Department of Social Services, this document allows for the exchange of information with agents from such community services. I understand that, under the law, the information provided will remain confidential, except in the following situations: 1) if it is deemed that I pose a danger to myself or others; 2) if concerns arise about potential abuse or neglect; or 3) if a court order is issued to obtain the records.

CONSENT FOR EMAIL, TEXT MESSAGES, OR VOICEMAIL

RISK OF USING EMAIL, TEXT MESSAGES, OR VOICEMAIL

The provider offers patients the opportunity to communicate via email, text messages, or voicemail. However, transmitting patient information via email, text messages, or voicemail has several risks that patients should consider before using email, text messages, or voicemail. These include, but are not limited to, the following risks:

A. Email, text messages, or voicemail may be distributed, forwarded, and stored in numerous paper and electronic files.

B. Email, text messages, or voicemail may be transmitted immediately around the world and received by many intended and unintended recipients.

C. Email, text messages, or voicemail senders may face miscommunication.

D. Email, text messages, or voicemail are easier to forge than handwritten or signed documents.

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E. Backups of email, text messages, or voicemail may exist even after the sender or recipient has deleted their copy.

F. Employers and online services have the right to archive and inspect emails or text messages transmitted through their systems.

G. Email, text messages, or voicemail may be intercepted, altered, forwarded, or used without authorization or detection.

H. Email, text messages, or voicemail may be used to introduce viruses into computer systems.

I. Email, text messages, or voicemail may be used as evidence in court.

CONDITIONS FOR USING EMAIL, TEXT MESSAGES, OR VOICEMAIL

The provider will use reasonable means to protect the security and confidentiality of email and text messages or voicemail information sent and received. However, due to the risks described above, the Provider cannot guarantee the security and confidentiality of emails, text messages, or voicemail communications, and will not be responsible for the improper disclosure of confidential information not caused by the Provider's intentional misconduct. Therefore, patients must consent to the use of email, text messages, or voicemail for patient information. Consent for the use of email, text messages, or voicemail includes an agreement to the following conditions:

A. All emails or text messages sent or received by the patient related to diagnosis or treatment will be printed and become part of the patient's medical history. Because they are part of the medical record, others authorized to access the medical record, such as staff and billing personnel, will have access to those emails or text messages.

B. The provider may internally forward emails or text messages to staff and agents of the provider as necessary for diagnosis, treatment, reimbursement, and other services. The provider, however, will not forward emails or text messages to independent third parties without the prior written consent of the patient, except as authorized or required by law. Although the Provider will strive to read and respond promptly to an email, text message, or voicemail from the patient, the Provider cannot guarantee that any email, text message, or voicemail will be read and responded to within any specific timeframe. Therefore, the patient will not use email, text messages, or voicemail for medical emergencies or other urgent matters.

D. If the patient’s email or text message requires or invites a response from the Provider, and the patient does not receive a response within a reasonable timeframe, it is the patient's responsibility to follow up to determine whether the intended recipient received the email, text message, or voicemail, and when they will respond.

E. The patient should not use email, text messages, or voicemail to communicate sensitive medical information, such as information about sexually transmitted diseases, HIV/AIDS, mental health, developmental disability, or substance abuse.

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F. The patient is responsible for informing the Provider of any type of information the patient does not want sent by email, text messages, or voicemail, in addition to those set forth in section 2(e) above.

G. The patient is responsible for protecting their password and other means of accessing email, text messages, or voicemail. The provider is not responsible for breaches of confidentiality caused by the patient or a third party.

H. The provider shall not engage in email, text message, or voicemail communications that are illegal, such as practicing medicine illegally across state lines.

I. It is the patient's responsibility to follow up and/or schedule an appointment.

INSTRUCTIONS

To communicate by email, text messages, or voicemail, the patient should:

A. Limit or avoid using their employer's computer.

B. Inform the Provider of changes to their email or text message address.

C. State the name of the patient.

D. Include the category of the communication in the subject line or email text message for routing purposes (e.g., billing inquiry).

E. Review the email, text message, or voicemail to ensure it is clear and all relevant information is provided before sending it to the Provider.

F. Inform the Provider that the patient has received an email, text message, or voicemail.

G. Take precautions to preserve the confidentiality of emails or text messages, such as using screen savers and safeguarding their computer password.

H. Withdraw consent only by email, text message, or written communication to the Provider.

Agreement:

• I acknowledge that I have been informed of my right to advance directives.

• I acknowledge receipt of the financial policy of Iriamar Vélez Quiñones, MD, and accept all terms and conditions stated therein.

• I acknowledge receipt of the Notice of Privacy Practices.

• I agree to allow access to my electronic prescription records as described above, as well as the use of electronic medical records and information exchange.

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• I agree to the release and assignment of benefits as described above.

• I agree to treatment as described above.

• I consent to the use of SMS, voicemail, email, or alternate communication methods.

• I have read this form, my questions have been answered, and I understand and accept its content. I understand I have been provided with the notification of policies of Dr. Iriamar Vélez Quiñones that provides a more comprehensive description of the use and disclosure of information. I understand I have the right to review the notification before signing this consent. I understand that Dr. Iriamar Vélez Quiñones reserves the right to change and/or modify their notification and information policies; and that I may obtain a copy of these changes by requesting them in writing. I understand that I have the right to object to the use of my health information for directory purposes. I understand I have the right to request restrictions on how my health information may be used or disclosed to carry out treatment, payment, and/or health operations, and that Dr. Iriamar Vélez Quiñones does not have to agree to the requested restrictions. I understand that I may revoke this consent in writing, except in cases where Dr. Iriamar Vélez Quiñones has already taken action.

- I request the following restrictions on the use or disclosure of my health information:

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I read or have had the above information read to me and fully understand these provisions.

_____ _____

Print Name/Relationship to Patient **Signature of Patient/Parent/Guardian**

_____ _____

Witness **Date**

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