Joel C. Ang, M.D., PC
Q Street Medical Associates
www.qstreetmds.com

HIPAA AUTHORIZATIONS
PATIENT CONSENTS

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Washington, DC 20009
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INTRODUCTION: As of April 14. 2003 the federal Government, under HIPAA requires all medical offices provide patients a copy of the privacy policy that the office follows, the requirement that the medical office obtain the patients signature giving consent for purposes of treatment, payment, and healthcare operations. Because of the government's requirement, and following the recommendations of the American Medical Association, we must obtain your signature acknowledging your acceptance of these policies. The entire privacy policy is available at the front desk; you may also download it from our website at www.qstreetmds.com. HIPAA regulations include provision for patients to obtain copies of their medical records. It's our practice to provide copies of your records during your visit. These regulations make it more important than ever for you to maintain your personal file of medical records. This document contains 4 independent releases.

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1) **REQUEST FOR SERVICES & RELEASE OF RECORDS TO PATIENTS:** I acknowledge and agree that I have personally requested medical care from Joel C. Ang, MD, and/or any other physician or health care practitioner at the office of Joel C. Ang, MD, PC. located at 1759 Q St. NW, Washington, DC 20009. I accept financial responsibility for any non-covered services, or charges deemed to be patient responsibility as determined by my insurance company, or if I am uninsured for the total bill of services. I understand that I will receive a copy of my medical records in the System Integrated Record, S.I.R.@ format, and laboratory & procedure results, prescriptions, referrals, and bills at the end of each visit. I agree that after I receive copies, Joel C. Ang, MD, PC., Custodian of Records, is not responsible for my release of records, or parts thereof, to any other party. I agree to keep each document for my medical records for my future use, such as other medical facilities, visits with consultants, or if I change physicians. I understand that each summary and the data which accompanies it are contained in the chart at Joel C. Ang, MD, PC., Custodian of Records, In the event I authorize another medical facility, or physician's office to obtain additional copies of records, or I request records for myself due to loss of copies given to me, I agree to pay $25.00 per visit document set. These fees are subject to change without notice. I understand that I will pay those fees in advance. I understand that the minimum patient record retention period in the District of Columbia is 3 years after my last visit with any physician associated with Joel C. Ang, MD, PC. or, for a minor child, 3 years after the patient reaches age 18, After such time my records may be destroyed at the discretion of the Custodian of Records and the rendering physician.

PATIENT OR PERSONAL REPRESENTATIVE: _____ _____ _____
SIGNATURE **PRINT NAME** **DATE**

2) **AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFO:** I authorize Joel C. Ang, MD, PC., Custodian of Records, to use and release my protected health information for the purpose of diagnosing health concerns/conditions/illnesses or providing treatment to me, obtaining payment for my health care bills, or to conduct other health care operations, for example but not limited to, 1) employees or physicians, 2) business associates of Joel C. Ang, MD, PC., 3) referrals for procedures, 4) other physicians or health care consultants to review my case, 5) required pre-approval from my insurance company, 6) prescription issuance by my designated pharmacy or prescription service, 7) reference laboratory testing, 8) submission of electronic or paper claims to obtain payment for healthcare services through 3rd party clearinghouses with which Joel C. Ang, MD, PC has established a business associates relationship, 9) incidental disclosure is also authorized in other matters that may relate to my health care. I have provided Joel C. Ang, MD, PC., Custodian of Records with my preferred phone number (with or without voicemail) and/or email address. This phone number, voicemail, and/or email address may be used by Joel C. Ang, MD, or any other physicians providing medical services on my behalf at 1759 Q St. NW, Washington, DC and the staff of Joel C. Ang, MD, PC. for the following, but not limited to, communication purposes: 1) appointment related matters, 2) billing communications, 3) physician/patient communications regarding my health care and health services rendered or planned. I understand that after Joel C. Ang, MD, PC., Custodian of Records, discloses my health information it may no longer be protected by privacy laws although certain federal laws and state law protection may still apply. I understand that I have the right to revoke this authorization by sending my written request to Jacqueline W. Schick, Office Administrator, Joel C. Ang, MD, PC., Custodian of Records, 1759 Q St. NW, Washington, DC 20009. I understand that my authorization is voluntary and that I may refuse to sign this authorization. I also understand that Joel C. Ang, MD, PC., Custodian of Records, may be limited in its ability to provide services to me since the provision of medical services may require the necessary exchange of medical information with other entities, such as, but not limited to employees and business associates of Joel C. Ang, MD, PC., Custodian of Records, my insurance company, reference laboratories, pharmacies, consulting physicians, etc.

PATIENT OR PERSONAL REPRESENTATIVE: _____ _____ _____
SIGNATURE **PRINT NAME** **DATE**

3) **EMERGENCY CONTACT DESIGNATION:** I have designated an emergence contact in my medical file. I authorize Joel C, Ang, M.D., and/or any other health care practitioner at the office of Joel C. Ang, MD, PC. located at 1759 Q St. NW, Washington, DC 20009, to disclose my protected health information to the designated emergency contact in the event of a life-threatening emergency or other illness requiring my immediate hospitalization.

PATIENT OR PERSONAL REPRESENTATIVE: _____ _____ _____
SIGNATURE **PRINT NAME** **DATE**

4) **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize Joel C. Ang, MD, PC., Custodian of Records, to apply for benefits on my behalf for covered services rendered to me, and I request that any all payments from my insurance company be made directly to Joel C. Ang, MD, PC. 1759 Q St. NW Washington, DC 20009 or the lockbox at Dept, 0525, Washington DC 20073-0525. I certify that the information I have reported with regard to my insurance coverage is correct and authorize the release of any necessary information, including medical information for this or any related claim, to the insurance company and/or the above named billing agent. I permit a copy of this authorization to be used in place of the original. Either the insurance company or I may revoke this authorization at any time in writing. If I choose not to sign the assignment of insurance benefits, I also assume all financial responsibility for any services rendered at the time of service.

PATIENT OR PERSONAL REPRESENTATIVE: _____ _____ _____
SIGNATURE **PRINT NAME** **DATE**

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare or Medicap benefits be made on my behalf to Joel C. Ang, MD, PC., Custodian of Records, 1759 Q St. NW, Washington, DC 20009 for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to Health Care Financing Administration and its Agents any information needed to determine these benefits or the benefits payable for related service.

MEDICARE/MEDIGAP PATIENT INITIALS: _____

**Authorization expires in one year. The signature of a personal representative is considered to have the full rights as the signature of the patient.*
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