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**GENERAL, VASCULAR AND LAPAROSCOPIC SURGERY**

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**Health Insurance Portability and Accountability Act (HIPAA)**

***Please carefully review this document***

**General Information**

Information about your treatment and care, including payment for care, is protected by two federal laws:

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the Confidentiality Law. Under these laws the practice must obtain your written consent before it can disclose information about you for payment purposes. For example, the practice must obtain your written consent before it can disclose any Personal Health Information (PHI). In addition, you must also sign a written consent before the practice can share information for any and all treatment purposes. However, federal law permits the practice to disclose information in the following circumstances without your written permission:

1. To practice staff for the purposes of maintaining the clinical records
2. Pursuant to an agreement with a business associate (e.g. Clinical laboratories, pharmacy, your insurance company)
3. For research, audit or evaluations (e.g. State licensing review, or accreditation as required by the State and/or Federal government);
4. To report a crime committed on the practice’s premises or against practice staff
5. To medical personnel in a medical/psychiatric emergency
6. To appropriate authorities to report suspected child abuse or neglect
7. To report certain infectious illnesses as required by state law
8. Information that is requested per a court order

Before the practice can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

**Disclosure of Medical Information**

I give my permission to the office of Great Lakes Surgical Associates to disclose medical information regarding my treatment/diagnosis to the following family members or friends whom you may speak with:

Name: Relationship: Phone:

Name: Relationship: Phone:

Name: Relationship: Phone:

Name: Relationship: Phone:

Name: Relationship: Phone:

Patient’s Signature: Date:

\*\*Copies are available at your request\*\*