DISCLOSURE OF PERSONAL HEALTH INFORMATION

First Name:_____ Middle Initial:_____ Last Name:_____

Mailing Address:_____

City:_____State:_____Zip:_____

Unity Health Network has implemented an electronic medical record in order to improve the efficiency in our offices and provide the highest quality healthcare services to our patients.

Unity Health Network adheres to the standards as defined for privacy of individually identifiable health information; which is commonly referred to as the privacy rule. The Privacy Rule standards address the use and disclosure of individuals' health information, better known as PHI (Protected Health Information). Also, Unity Health Network follows the regulations associated with the Health Insurance Portability and Accountability Act (HIPAA); a notice of our privacy practices is available to you upon request.

We need to obtain your permission to release or share your protected health information. Please complete this form in order for Unity Health Network to release your medical records.

Ohio Public Health Reporting

To keep track of patients' adult and childhood immunizations and health information, your **Unity Health Network providers** use the Ohio Department of Health secure, online system, called Impact Statewide Immunization Information System (ImpactSIIS). In addition to immunizations, body mass index, vision, lead, tuberculosis and hearing measures are reported to ImpactSIIS. The primary benefit of ImpactSIIS is that state of Ohio authorized users like schools, local health departments, immunization providers and Women Infants and Children (WIC) program staff, may access your immunization and health information, even if you move. Please note that not all authorized entities use ImpactSIIS. If you have additional questions about ImpactSIIS, please call the Ohio Department of Health at 1-866-349-0002 or (614) 466-4643, or send an email message to impact@odh.ohio.gov. If you do not want your immunization and health information included in ImpactSIIS, ask your provider or the Ohio Department of Health for the ImpactSIIS Removal Request form.

We hope you recognize the importance of the steps we are taking in order to provide high quality, efficient healthcare services. As always, our patients are our number one priority.

Personal Health Information Release/Emergency Contacts:

Name: _____

Relationship: _____

Home Phone #: _____

Cell Phone #: _____

Is this person able to receive your Personal Health Information? ☐ Yes ☐ No

Name: _____

Relationship: _____

Home Phone #: _____

Cell Phone #: _____

Is this person able to receive your Personal Health Information? ☐ Yes ☐ No

What is your preferred contact number for appointment reminders and messages?

Preferred Phone#: _____

What is your preferred time of day for appointment reminders and messages?

☐ Morning ☐ Afternoon ☐ Evening

Would you like to be web-enabled for our patient portal? ☐ Yes ☐ No

If yes, please provide your email address: _____

Preferred Pharmacy Name: _____

Preferred Pharmacy City: _____

Preferred Pharmacy Phone Number: _____

☐ Retail Pharmacy ☐ Mail Order Pharmacy

On occasion, we may need to call you and leave information regarding results of any treatments or tests that you have had. May we leave this information on your voicemail? ☐ Yes ☐ No

If yes, please circle preference:

Home Phone or Cell Phone

Brief or Extended

In order for us to service our account or to collect any amounts you may owe, we, as well as any agency contracted by us, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We, as well as any agency contracted by us, may also contact you by sending text messages or emails using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I, _____, do hereby acknowledge notification of the Notice of Privacy Practices, Policies and Procedures.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____