Heart Rhythm Clinic of Michigan
Mustafa Hassan, MD, FACC, FHRS

1335 South Linden Road,
Suite #A, Flint, MI 48532
P: (810) 285-8501
F: (810) 285-8468

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The following information is a summary of HIPAA's NOTICE OF PRIVACY PRACTICES, which is posted in the office in full text. **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.**

We are required by law to maintain the privacy of your medical information. We must provide you with a copy of this notice. We must follow the terms of this notice. If the notice is changed in any material way, a revised notice will be available upon request.

We will use your medical information for **Treatment.** For example, a physician who is providing your care will report any changes in your condition to your physician(s). We will use your medical information for **Payment.** For example, we may need to give your insurance plan information about your diagnosis, treatment and supplies used. We will use your medical information for **Health Care Operation.** For example, we may use your medical information to evaluate our services. We may contact you at any phone number or address you have provided to remind you of an appointment or other health care matters or to obtain payment for our services rendered.

We may use and disclose your medical information to inform you of treatment alternatives or other health related benefits and services. We may disclose your medical information to family members or others who are involved in your care of payment for that care, provided we have a signed release or POA on file.

We may use your medical information for any uses that are required or permitted by law. Other uses and disclosures will be made only with your written authorization. You may cancel an authorization at anytime by notifying us in writing.

You have the following rights: **Right to privacy notice; Right to request restriction on uses and disclosures of your medical information; Right to receive confidential communications; Right to inspect and copy your medical information; Right to request an amendment to your medical information; and Right to an accounting of disclosures of your medical information.**

Acknowledgment of Receipt of Privacy Practices

As a patient of Heart Rhythm Clinic of Michigan, under the care of Dr. Mustafa Mahmoud Hassan, acknowledge that I have received the Notice of Privacy Practice and understand it. I also understand that I may request a Full Text Notice of Privacy Practice at anytime.

Signature: ______________________________________

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Medical Information Release Form

HIPAA Release Form

Patient Name: ______________________________ DOB: ____/____/_____

Release of Information

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claim form. This information may be released to:

☐ Spouse ______________________________
☐ Child(ren) ______________________________
____
____
☐ Other ______________________________
☐ Information is not to be released to anyone.

This **Release of Information will remain in effect until terminated by me in writing.**

Messages

Please call ☐ my home ☐ my work ☐ my cell number

____________ ____________ ____________

IF unable to reach me:

☐ You may leave a detailed message
☐ Please leave a message asking me to return your call
☐ ______________________________

The best time to reach me is (day) ____________ between (time) ____________

Patient Signature: ______________________________ Date: ____/____/____

Witness: ______________________________ Date: ____/____/____

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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R Parts 160 and 164)

Name: ______________________________ DOB: ____/____/____

I hereby authorize ______________________ its Director of designee, to release information contained in the medical records of the patient identified above. I authorize the release of drug and alcohol abuse records in accordance with Federal Regulation and/or communication made by me to a social worker or communications made by me to a social worker or psychologist and/or record pertaining to communicable diseases. I specifically authorize the release of information regarding:

____ Human Immunodeficiency Virus (HIV) ____ Acquired Immunodeficiency Syndrome (AIDS)
____ Acquired Immunodeficiency Related Complex (ARC)

The information may be released to the following:

Heart Rhythm Clinic of Michigan
Dr. Mustafa Hassan, MD, FACC, FHRS
1335 S. Linden Rd. Suite A
Flint, MI 48532

Specific Information to be disclosed: ______________________________
____ Medical Record Summary Other ______________________________
____ Entire Medical Record
____ Transfer of Device Clinic, including ICD/PPM/LOOP recorder

Purpose and need for such disclosure: ______________________________

This consent is subject to revocation at any time except in those cases in which the Hospital has acted with the understanding that the consent will continue in effect until the stated purpose has been accomplished. However, any consent given with respect to substance abuse records shall have duration no longer than is reasonably necessary to effectuate the purpose for which it is given.

Without express revocation, the consent expires 6 months subsequent to signing, or on the date set forth below, or for the following specified reasons.
DATE: ___/___/___, or event ______________________________
Condition: ______________________________

NOTE: A COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL

______________________________ ____________________
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

____
PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE AND RELATIONSHIP OF MEMBER

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General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risk and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I hereby certify that neither Dr. Hassan nor any of Heart Rhythm Clinic of Michigan staff, solicited me by phone, mail or otherwise to choose them as providers for my health care. I chose Dr. Hassan as my provider on my own accord.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________	______________________________
Signature of Patient or Personal Representative	**Date**
______________________________	______________________________
Printed Name of Patient or Personal Representative	**Relationship to Patient**