SYED A. A. ZAIDI, MD, PLLC
CONFIDENTIALITY AND YOUR MEDICAL RECORDS

The following information is designed to inform you of your rights and responsibilities established under the Health Insurance Portability and Accountability Act of 1996.

FAXING MEDICAL RECORDS
Medical records will not be faxed to other physicians without written permission to do so from you. You must sign a medical release form stating which information you want released and provide us with the name and fax number where those records should be sent. If we refer you to a specialist, we will forward any necessary records as part of the referral, in order maintain continuity of care. If you should require your records for personal or legal use, there will be a fee charged for those records.

TEST RESULTS
Test Results cannot be left on your answering machine. We may leave you a message asking you to either return to the clinic or call us to discuss your results and treatment options

RELEASE OF MEDICAL AND FINANCIAL INFORMATION TO YOUR FAMILY
We do not release medical information to any person except you without your written permission, with the exception of a minor child or adult under the legal guardianship of another adult.

T.C.A. 63-6-233 does state that a physician may for the purpose of providing prenatal care or contraceptives, examine, diagnose and treat a minor child without the consent or knowledge of the legal guardian. Therefore, we may require a signed consent form from a minor to release this information to a legal guardian or parent.

We cannot discuss your bill with anyone but you, without your written permission to do so. This includes your spouse or other family member, unless they have a power of attorney on file in our office.

I authorize Syed A. A. Zaidi, MD PLLC discuss my medical condition(s) and/or financial issues (which include test results, diagnosis, possible treatment options and billing and insurance issues) with the following family members:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

NOTICE OF PRIVACY PRACTICES
I understand that upon signing this consent, I have been given a copy of Syed A. A. Zaidi MD, PLLC's Notice of Information Practices for more information about how my protected health information may be used and disclosed. I understand that Syed A. A. Zaidi MD, PLLC may change its information practices, but before doing so, will post a new Notice in the waiting area and I may also call 731-221-1637 to request a copy of the Notice during business hours. I understand that I have the right to revoke this consent, in writing, except where Syed A. A. Zaidi MD, PLLC has already made disclosures in reliance on my prior consent. **INITIALS:**_____

MEDICATION HISTORY
I authorize Syed A. A. Zaidi MD PLLC to obtain my medication history from my pharmacy. **INITIALS:**_____

CONFIRMATION OF APPOINTMENTS
As a courtesy to you, we do call to remind you of the date and time of your appointment. If you are not available a message will be left with this information. **INITIALS::** _____

I UNDERSTAND THAT MY SIGNATURE EXPRESSES AN UNDERSTANDING OF THE CONFIDENTIALITY REQUIREMENTS LISTED ABOVE. I UNDERSTAND THAT THIS CONSENT IS VALID UNTIL I REVOKE IT IN WRITING.

PATIENT NAME:_____ SIGNATURE:_____ Date:_____