Mind Rejuvenation, LLC
Iftikhar Hussain, MD
Mical Pacheco, MSN, APRN, PMHNP-BC

PH: (918) 340-6460
FX: (918) 926-3376
4922 E 73rd St, Tulsa, OK 74136

Health Insurance Portability and Accountability Act of 1996(HIPAA)

Name: _____ DOB: _____ Date: _____

Please review each section below and place your initials to confirm that you have read and understand the information provided.

_____ AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I authorize Mind Rejuvenation / AAIC to use and disclose my Protected Health Information (PHI) and individually identifiable health information to me, my authorized representative listed above, and to representatives of local, state, or federal agencies, insurance companies, or other organizations as permitted by federal or state law, including for the review and payment of claims.

I also authorize Mind Rejuvenation / AAIC to share my health information with physicians, hospitals, and other healthcare providers for purposes of treatment or coordination of care. This information may include, but is not limited to, medical history, diagnoses, and treatment information.

Right to Revoke: I understand that I may revoke this authorization at any time by providing written notice to Mind Rejuvenation / AAIC, except to the extent that action has already been taken based on this authorization.

Expiration: This authorization will remain in effect until revoked in writing by the patient or as otherwise permitted by law.

Redisclosure Notice: I understand that information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected under federal privacy regulations (HIPAA).

_____ ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONDITIONS OF TREATMENT

I acknowledge that I have received, or have been offered, the Notice of Privacy Practices (dated June 1, 2018) and the Conditions of Treatment for Mind Rejuvenation / AAIC.

I understand that Mind Rejuvenation / AAIC maintains medical records describing my symptoms, examinations, test results, diagnoses, treatment, and future care plans. This information may be used for treatment, payment, and healthcare operations, including communication with other healthcare providers, quality assessment, and administrative functions, as permitted by law.

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_____ AUTHORIZATION TO CONTACT PATIENT / ACCOUNT REPRESENTATIVE

I authorize physicians and staff of Mind Rejuvenation / AAIC to contact me and/or leave detailed messages by mail, phone, voicemail, text message, or email regarding laboratory results, clinical information, and account balances.

EMERGENCY CONTACTS

Please list two emergency contacts below.

NOTE: These contacts will NOT receive personal or medical information (except information necessary in a medical emergency) unless you authorize the release of medical information.

1. Name: _____ Phone: _____

   Relationship to Patient: _____

   May we share the patient's medical information with this contact? ☐ Yes ☐ No

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2. Name: _____ Phone: _____

   Relationship to Patient: _____

   May we share the patient's medical information with this contact? ☐ Yes ☐ No

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I certify that I have reviewed the information above and have initialed each section to indicate my understanding.

_____

Patient / Parent / Legal Guardian (PRINT Name)

_____ _____

Patient / Parent / Legal Guardian (SIGNATURE) Date