INFECTIOUS DISEASE & EPIDEMIOLOGY ASSOCIATES, PC
17030 Lakeside Hills Plaza, #202, Omaha, NE 68130

Patient's Name _____ Date of Birth _____

Notice of Privacy Practices: I, the undersigned, have received and/or been offered a separate document informing me of my rights and responsibilities as a patient. I understand that the *Notice of Privacy Practices* may be revised at any time and that I may request a copy by writing to the above practice. I may also revoke any part of this authorization by writing to the above address. If so revoked, it will not affect any actions already taken by the above practice. I may not be able to revoke this authorization if its purpose was to obtain insurance.

My Rights: I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment or enrollment). In the event I am asked to participate in a research study, or to receive health care when the purpose is to create health information for a third party, I will be asked to sign an authorization.

Once this office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Authorization to Release Information:
We may release relevant health information and/or billing information associated with your treatment upon request if we can reasonably infer, based on professional judgment that the patient does not object. **If you do not want information to be released, inform IDEAS personnel.** If you have specific objections or instructions regarding these communications, you may discuss them with IDEAS personnel and make the changes in writing at any time. This signed authorization form allowing release of information remains valid unless the patient requests a change.

If I am unable to be reached, I give my permission to have messages regarding my appointment time, changes of, or scheduling information left on my answering machine, on voice mail, or with a family member or person answering the phone.

Please initial: _____ I acknowledge receipt of IDEAS *Notice of Privacy Practices.*

The undersigned certifies that he or she has read the foregoing, is the patient, patient's guardian, power of attorney, parent, or is duly authorized by or on behalf of the patient to execute the above and accept its terms.

_____
Patient's Signature/Parent if Minor/Power of Attorney/Guardian Date

_____
Responsible Party's Signature (If Not Same as Patient or Parent) Insured Signature

_____
Witness to Signatures (IDEAS Representative):

The patient was provided a copy of the IDEAS *Notice of Privacy Practices.* A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. Patient was unable to sign consent because: