



HIPAA Training May

PF-5000 Authorization to Communicate
Patient's Medical Information

*Let's Taco
bout' it*



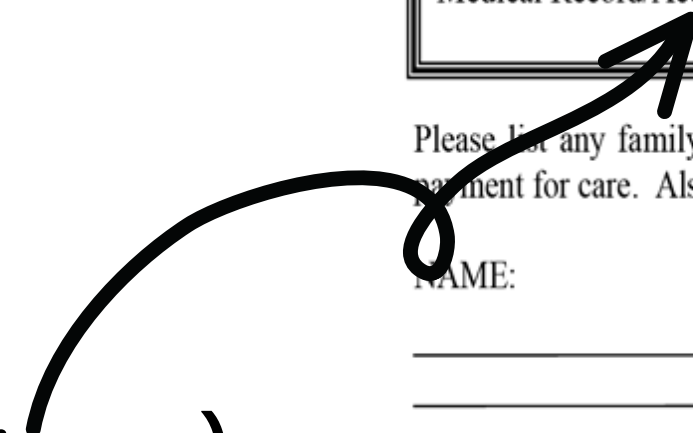
****Must be completed and filed
for every patient*

Who can we talk to about your medical information?

Fill out the whole form.



TIP : Start with the basics ;)



PF - 5000
**AUTHORIZATION TO COMMUNICATE
 PATIENT'S MEDICAL INFORMATION**

COMMUNICATION WITH FAMILY &
 OTHERS INVOLVED IN YOUR CARE

(Signed original to be placed in the central
 medical record and copy to patient)

PATIENT IDENTIFICATION
 Name: _____
 Date of birth: _____
 S.S. #: _____
 Medical Record/Account#: _____

Office Name: _____
 Address: _____
 City/State/Zip: _____
 Phone number: _____
 Fax number: _____
 Physician name: _____

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

NAME:	RELATIONSHIP TO PATIENT	TYPE OF INFORMATION			
		ALL	Scheduling/ Appointment	Medical	Billing/ Insurance

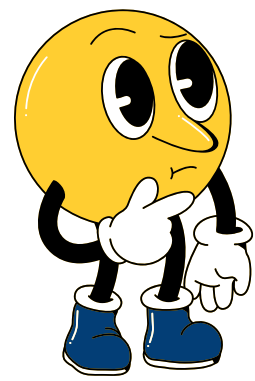
Specific instructions or limitations: _____

Validation code: _____ (Please give this to any individual who may be involved in coordinating your care or payment for care. They will be asked to give this code to our staff before we release information over the phone.)

We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. You are authorizing those listed to receive your protected health information. Please promptly notify your physician's office if you wish to alter the designations above.

Signature of Patient/Legal Representative: _____ Date: _____

Relationship to patient: _____



Let's Get Into Specifics

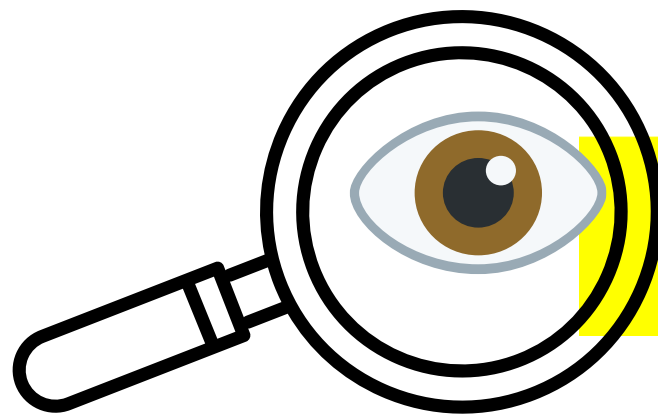
Who can we tell and what?

- **"ALL" ? Spouse
Granddaughter? etc...**

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

NAME:	RELATIONSHIP TO PATIENT	TYPE OF INFORMATION			
		ALL	Scheduling/ Appointment	Medical	Billing/ Insurance

Specific instructions or limitations: _____



The Validation Code:

Validation code: _____ (Please give this to any individual who may be involved in coordinating your care or payment for care. They will be asked to give this code to our staff before we release information over the phone.)

HIPAA Form PF - 6000



Form PF-6000
HIPAA FORM FOR
RECORDS DESTRUCTION



OFFICE NAME: _____
OFFICE ADDRESS: _____
PHYSICIAN NAME(S): _____

CERTIFICATE OF DESTRUCTION

The information described below was destroyed in the normal course of business pursuant to the organizational retention schedule and destruction policies and procedures.

Date of Destruction: _____ Authorized By: _____

Description of Information Disposed Of/Destroyed: _____

Inclusive Dates Covered: _____

METHOD OF DESTRUCTION:

- Burning
- Overwriting
- Pulping
- Pulverizing
- Reformatting
- Shredding
- Other: _____

Records Destroyed By*: _____

If On Site, Witnessed By: _____

Department Manager: _____

**If records destroyed by outside firm, you must confirm a contract exists*

*Keep the form onsite
File in your HIPAA Manual
or HIPAA File*



Completing the Form:

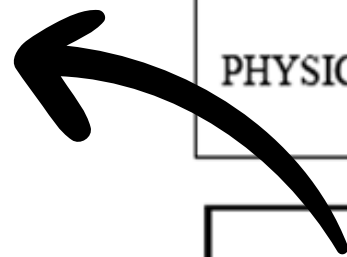
- **Date of destruction**
- **Authorized by:** Provider?
Office Manager?...
- **What was destroyed:**
Medical Recs, including
paper chart, x-ray, etc....
- **Files with last date of
service** July 1, 2007 or before
including files from 2006,
2005, etc.



Form PF-6000
HIPAA FORM FOR
RECORDS DESTRUCTION



OFFICE NAME: _____
OFFICE ADDRESS: _____
PHYSICIAN NAME(S): _____



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Completing the form:

METHOD OF DESTRUCTION:

- Burning
- Overwriting
- Pulping
- Pulverizing
- Reformatting
- Shredding
- Other: _____

Better not be the dumpster



Mark how the records were destroyed, cannot be thrown in the trash/dumpster



Records Destroyed By*:

If On Site, Witnessed By:

Department Manager:

**If records destroyed by outside firm, you must confirm a contract exists*