Louisiana Authorization (HIPAA) to Release or Obtain Health Information
(including paper, oral and electronic information)

Name	Request Date
Mailing Address	Date of Birth
City/State/Zip	Social Security or ID Number

I authorize:

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: _____

❒ **TO RELEASE Information TO** **OR** ❒ **TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number: _____

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

❒ Further Medical Care ❒ Personal ❒ Legal Investigation or Action ❒ Changing Physicians
❒ Research related treatment ❒ Creating health information for disclosure to a third party.
❒ Other: (Specify)_____

I authorize the release of the following protected health information.
(Place an "X"in the box(es) that apply to the information you want released or you want to obtain.)

❒ Entire Record ❒ Medical History, Examination, Reports ❒ Surgical Reports ❒ Treatment or Tests
❒ Prescriptions ❒ Immunizations ❒ Hospital Records including Reports ❒ Laboratory Reports
❒ X-ray Reports ❒ MR/DD Records ❒ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

❒ Alcoholism † ❒ Drug Abuse † ❒ Mental Health ❒ Vocational Rehabilitation ❒ HIV (AIDS)
❒ Sexually Transmitted Diseases ❒ Genetics ❒ Psychotherapy Notes
❒ Other_____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form.

_____ _____
Signature of Individual or Personal Representative Authorized by Law Date

BRYANT
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INFORMED CONSENT FOR INTEGRATIVE MEDICAL TREATMENT

As a patient, I have the right to be informed about my condition and recommended care. This disclosure is to help me become better informed, so I may make the decision to give or withhold my consent as whether or not to undergo care having had the opportunity to discuss potential benefits, ricks, and hazards involved.

I hereby request and voluntarily consent to examination and treatment with integrative medical care, possibly including vitamins, minerals, supplements, IV therapies, injections, detoxification treatment modalities, lab testing, nutrition recommendations, ect. for me (or for the patient named below, for whom I am legally responsible) by Brian LeCompte MD and Bryant Medical Group. I can request further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment.

I understand that the U.S. Food and Drug Administration has not fully evaluated or approved nutritional and herbal supplements, compounded IV's / injections, and bioidentical hormone replacement therapies; however, they have been widely used in Europe and the U.S. for years. I understand that, as with drugs, hormones, nutritional supplements, herbal, and homeopathic remedies, ozone, nutritional IV therapies and injections may exhibit some side effects in certain sensitive individuals, may interact with certain allopathic medications or lab tests or show symptoms, due to certain pre-existing disease conditions. I do not expect the medical practitioner to be able to anticipate and explain all risks and complications, and wish to rely on the medical practitioner to exercise judgment in recommending the dietary supplements, medications, and treatment, that the medical practitioner feels at the time, based on the facts then known, is in my best interest. I understand that if I do not take the supplements or treatments as recommended, I may not get the desired result or may increase chances for an adverse effect.

It is my responsibility to keep my medical practitioner up to date with all of the current medications and supplements that I am taking, so that he / she can make the best informed recommendations for my care.

I have the opportunity to ask questions and discuss with my medical practitioner to my satisfaction:

- My suspected diagnosis or condition.
- The nature, purpose, and potential benefits of the proposed care.
- The inherent ricks, complications, potential hazards, or side effects of the treatment or procedure.
- The probability or likelihood, of success.
- Reasonable available alternatives to the proposed treatment or procedure.
- The possible consequences if treatment or advice is not followed and / or nothing is done.

I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

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INFORMED CONSENT FOR INTEGRATIVE MEDICAL TREATMENT

I understand that integrative medicine, evaluation and treatment may include, but is not limited to: collecting specimens for laboratory evaluation, ordering diagnostic imaging, prescription of certain medications and nutritional supplements, IV therapy, and bio-identical hormone replacement therapy, injections, counseling, dietary therapies, PRP or other alternative remedies.

I understand that Dr. LeCompte at Bryant Medical Group has been trained in a diverse range of diagnostic and treatment options. I understand that Bryant Medical Group is highly specialized and based upon evidence-based medicine, including functional medicine and holistic principles. As such we may recommend different tests; may interpret standard tests differently; may propose different treatments or may administer standard treatments differently from most conventional physicians as many perspectives exit in medicine and in some cases, there may be a disagreement among qualified medical experts. Care rendered may therefore be seen by some as outside standard of care or medically unnecessary. Diagnosis and treatment may include some services that are considered non-traditional, nonconventional or alternative medicine. These services may not be recognized as standard medical practices and may be considered by insurance companies to be experimental or investigational. Along with training, the rationale for these differences is based on clinical experience and ongoing continuing education in evidence based functional and integrative medicine.

I fully release, waive discharges and covenants to hold harmless Bryant Medical Group, Brian LeCompte, MD, agents, employees and designees from any and all losses, causes of action, claims, damages and liability that I , my spouse, child(ren), guests, legally authorized representative, assigns, successors and representatives may have that relates to, arises out of or is anyway connected to my use of the facility or my participation in facility activities. I agree to defend indemnify and hold harmless Bryant Medical Group, agents, employees or designees from and against any and all claims of any nature including cost, expenses, and fees arising out of or resulting from my actions during the facility's activities or events. I consent to receive emergency medical treatment which may be deemed advisable in the event of injury, accident or illness while at Bryant Medical Group or while participating in the facility activities.

In case of acute care or serious illness, please call 911 or go to the nearest ER center.

By signing this form I acknowledge I have carefully read, or have had read to me, and understand the above consent. I give my permission and consent to care and authorize medical treatment by Bryant Medical Group and staff, and I am fully aware of what I am signing. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment and I may ask my physician for a more detailed explanation.

_____ _____

PRINT PATIENT NAME DOB

_____ _____

SIGNATURE OF PATIENT (OR GUARDIAN) DATE

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Notice of Privacy Practices (HIPAA)

****This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please read it carefully.****

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program that requires that all medical records and other individually identifiable health information used or disclosed by Ballen Medical and Wellness in any form, whether electronically, on paper, or orally are kept properly confidential. HIPAA gives you, the patient, the right to understand and control how your personal health information (PHI) is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for the following purposes: treatment, payment, and health care operation.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this is if you are referred to a primary care doctor or another specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit. (Please note that Ballen Medical and Wellness does not submit to insurance.)
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would-be patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement or other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related enemies and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of your PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes (these are not part of your medical record under HIPAA).
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations.
- Disclosures that constitute a sale of PHI under HIPAA.
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI

- The right to request restrictions in certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of the initial date of service and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Receipt of Notice of Privacy Practices and Written Acknowledgement Form

Patient Name: _____ Date of Birth: _____

I am a patient of Bryant Integrated Medical. I, _____hereby acknowledge receipt of Bryant Integrated Medical s' Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if patient is under the age of 15)

Information Release Form
(HIPAA Release Form)

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Name:_____
Date of Birth _____

Release of Information:

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. 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 patient in writing.

Messages:
Please call:
[ ] my home
[ ] my work
[ ] my cell phone number: _____

If you are unable to reach me, you: [ ] may leave a detailed message with the person(s) authorized to receive information, [ ] may leave a detailed message on my cell phone voice mail, [ ] may leave a message asking me to return your call with the person (s) authorized to receive information, [ ] may leave a message on my cell phone voice mail to return your call, [ ] may text or email me detailed information, [ ] may text or email me asking me to return your call.

The best time to reach me is (day) _____ (time)_____

Signature of Client_____
Date _____

Signature of Witness _____
Date _____