

William A. Atlas, M.D.
Internal Medicine
“Patient Centered Concierge Medicine”

To: William Atlas, M.D.

From: _____

Fax: (210) 404-9223

Phone: _____

Thank you for choosing William A. Atlas, M.D. In an effort to expedite your check-in process as a new patient, please complete the new patient forms before your appointment and either fax or bring them with you to your appointment.

Items to bring to your appointment:

- 1). New Patient Forms
- 2). Insurance Card(s) and Driver’s License
- 3). Any and all relevant medical records
- 4). Current Medications

Office Information:

William A. Atlas, M.D., P.A.
540 Madison Oak Suite 550
San Antonio, Texas 78258
Ph: (210) 404-9220 Fax: (210) 404-9223

Again, thank you for choosing William A. Atlas, M.D. If you have any questions please feel free to contact our office staff. We look forward to seeing you.

New Patient Updated Information

William A. Atlas, M.D.
540 Madison Oak Suite 550
San Antonio, Texas

P: 210.404.9220 F: 210.404.9223

Patient Demographics

Patient Name: _____ Birth Date: ____/____/____
LAST FIRST MI

Social Security No: ____ - ____ - ____ Gender: Male Female

Address: _____
STREET ADDRESS CITY STATE ZIP

Home #: ____ - ____ - ____ Cell #: ____ - ____ - ____ Work #: ____ - ____ - ____

Marital Status: Married Single Divorced Widowed Preferred Language: _____

Race: African American American Indian/Alaska Native Asian Hispanic
 Native Hawaiian / Pacific Islander White Other

Ethnicity: Hispanic or Latin Decent Not Hispanic or Latin Decent Do Not Wish to Report

Emergency Contact Information

Name: _____ Phone: ____ - ____ - ____

Release of Medical Information

(Medical Information may be released to the following individuals)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Payment Information

Form of Payment: Health Insurance Auto Insurance Workers Comp Self Pay Other

Primary Insurance:

Primary Company: _____ Insured's Name: _____

Policy #: _____ Group #: _____ Insured's Date of Birth: _____

Secondary Insurance

Secondary Company: _____ Insured's Name: _____

Policy #: _____ Group #: _____ Insured's Date of Birth: _____

Self Pay Agreement

I agree to pay for medical services rendered from William A. Atlas MD PA. I understand that payment arrangements must be made prior to establishing as a new patient.

Patient Signature: _____ Date: _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize William A. Atlas MD PA and affiliated providers to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process any claim associated with William A. Atlas MD PA and affiliated providers with respect to my medical care. I permit a copy of this authorization to be used in the place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to the affiliated providers of William A. Atlas MD PA. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

CONSENT FOR TREATMENT:

I hereby authorize the health care providers affiliated providers to perform a physical examination and to provide any medical treatment deemed necessary. This includes but not limited to all required medical examinations, echocardiograms, EKG, nuclear scans, x-rays, and/or medical / surgical procedures.

PATIENT PAYMENT RESPONSIBILITY:

I hereby agree that all applicable fees, deductibles, co-insurance, and co-payments are my responsibility and must be paid at the time services are rendered, unless payment arrangements have been made.

APPOINTMENT CANCELLATIONS:

I hereby agree to make every attempt to call the office at least 24 hours in advance of any appointment that needs to be cancelled or rescheduled.

CHANGE OF INFORMATION:

I hereby agree to provide the office any information regarding changes in my address, phone number, health benefits, or insurance information.

NOTICE OF PRIVACY PRACTICES:

William A. Atlas MD PA and affiliated providers are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgement of receipt of our office’s Notice of Privacy Practices.

AUTHORIZED SIGNATURE:

I authorize that I have read this document and will comply with the policies listed above. I also understand and agree that William A. Atlas MD PA and affiliated providers reserve the right to terminate the physician/patient relationship for non-compliance with any of the above policies.

Patient Name (Please Print)

Date

Patient Signature

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of William A. Atlas MD PA and affiliated providers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of William A. Atlas MD PA and affiliated providers reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of William A. Atlas MD PA and affiliated providers may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of William A. Atlas MD PA and affiliated providers may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the office of William A. Atlas MD PA and affiliated providers may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of William A. Atlas MD PA and affiliated providers restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that the office of William A. Atlas MD PA and affiliated providers may use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the office of William A. Atlas MD PA and affiliated providers may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Print Name of Patient or Legal Guardian

Date

New Patient Health Questionnaire

NAME: _____ **Birth Date:** ____/____/____ **Age:** _____
LAST FIRST MI

Preferred Pharmacy: _____ Phone #: _____

Allergies / Sensitivity to Medications: _____

Chief Complaint for Visit: _____

Symptoms / Condition: (Do you or have you had any of the following in the last 3 months.)

- | | | |
|--|---|--|
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Hemoptysis (Coughing up Blood) | <input type="checkbox"/> Passing Out |
| <input type="checkbox"/> Bleeding Ulcers | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Light Headed/Dizziness | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Claudication (Pain in legs) | <input type="checkbox"/> Numbness / Tingling | <input type="checkbox"/> Swelling of Ankles / Legs |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pain with breathing | <input type="checkbox"/> Unusual Fatigue |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Palpitations | |

Past Cardiovascular History: (Do you or have you had any of the following?)

- | | |
|---|---|
| <input type="checkbox"/> Ablation | <input type="checkbox"/> Electrocardioversion / Shock |
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Heart Failure |
| <input type="checkbox"/> Aortic Aneurysm/ Dissection | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Arrhythmia (fast or slow rhythms) | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Atrial fibrillation/Flutter | <input type="checkbox"/> Myocardial Infarction |
| <input type="checkbox"/> Cardiac Bypass Surgery (CABG) | <input type="checkbox"/> Pacemaker/ ICD (Defibrillator)/CRT |
| <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Pericardiocentesis / IVC Filter |
| <input type="checkbox"/> Cardiovascular Transplant | <input type="checkbox"/> Peripheral Artery Disease |
| <input type="checkbox"/> Carotid Endarterectomy / Stent | <input type="checkbox"/> Peripheral Bypass / Vascular Surgery |
| <input type="checkbox"/> Congenital Heart Disease /Surgery | <input type="checkbox"/> Peripheral Stent |
| <input type="checkbox"/> Coronary Artery Disease (Blocked Arteries) | <input type="checkbox"/> Sudden Death |
| <input type="checkbox"/> Coronary Stent (PCI) | <input type="checkbox"/> Valve Repair / Replacement |

Past Medical History: (Circle if you have or had a history of the following)

- | | |
|--|--|
| <input type="checkbox"/> Anxiety Disorder/Depression | <input type="checkbox"/> Have you had MRSA/VRE? Year? _____ |
| <input type="checkbox"/> Arthritis / Rheumatoid Arthritis | <input type="checkbox"/> Mental Health Problems |
| <input type="checkbox"/> Blood / Bleeding Disorders | <input type="checkbox"/> Peripheral Disease |
| <input type="checkbox"/> Cancer (Chemo/Radiation) | <input type="checkbox"/> Preeclampsia / Eclampsia |
| Type of Cancer: _____ | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Connective Tissue Disease/Disorder | <input type="checkbox"/> Pulmonary Hypertension |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> PVD / Claudication- (Leg pain caused by activity) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Renal Artery Stenosis |
| <input type="checkbox"/> Eye / Vision Disorders | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Heart Disease / Heart Attack | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Disorders |
| <input type="checkbox"/> High Cholesterol / Triglycerides | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Stomach/ Intestinal Prob. _____ |
| <input type="checkbox"/> Kidney Disease / Dialysis | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Liver Disease / Hepatitis | <input type="checkbox"/> Syncope |
| <input type="checkbox"/> Lung Disease - (Asthma/Emphysema) | <input type="checkbox"/> Varicose Veins |

Past Surgical History: (Major and Minor Surgery)

YEAR	MAJOR SURGERY

NOTICE OF PRIVACY PRACTICES

WILLIAM A. ATLAS, M.D., P.A.

540 Madison Oak, Suite 550

San Antonio, TX 78258

Effective Date: September 23, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart, on a computer, and/or in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.
2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Officer.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.
8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]
22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your

request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the bottom of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Jorge Lozano, Regional Manager, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169, Dallas, TX 75202
Voice Phone (800) 368-1019 FAX (214) 767-0432 TDD (800) 537-7697
OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

Privacy Officer: Chris Mathis
Address: 540 Madison Oak, Suite 550, San Antonio, TX 78258
Phone: 210-404-9220 Fax: 210-404-9223

William A. Atlas, M.D.

Patient Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: ____/____/____

Address: _____ SS#: _____-_____-_____

I hereby authorize the physician / practice (Disclosing Physician/Practice) listed below to release my Protected Health Information (information contained in my medical records) to William Atlas, M.D.

Disclosing Physician / Practice: _____.

Description of Information to be Disclosed:

<input type="checkbox"/> Complete Medical Record	<input type="checkbox"/> Labs Reports / Tests
<input type="checkbox"/> Chest X-Rays	<input type="checkbox"/> Nuclear Stress Test
<input type="checkbox"/> Echocardiograms	<input type="checkbox"/> EKG Test / Results
<input type="checkbox"/> Office Notes	<input type="checkbox"/> Holter Monitor Results

Protected Health Information to be Disclosed to:

**William A. Atlas MD PA
Attn: Medical Records
540 Madison Oak Suite 550
San Antonio, Texas 78258
P: (210) 404-9220 F: (210) 404-9223**

Purpose of Disclosure:

<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Change of Doctor
<input type="checkbox"/> Referral to Specialist	<input type="checkbox"/> Other: _____

I understand the following:

- 1). I may revoke this authorization at any time by providing written notice William Atlas, M.D.
- 2). I may not be able to revoke this authorization once the office has utilized the information received, or if the authorization was obtained as a condition of obtaining insurance coverage.
- 3). William Atlas, M.D. will not condition treatment or payment based upon my signing of this authorization.
- 4). The information disclosed by this authorization may be subject to re-disclosure by William Atlas, M.D. and no longer protected by Federal Law.
- 5). I have reviewed this Authorization and understand it's purpose and intent
- 6). This Authorization is valid until or unless I submit in writing a request of revocation to the practice.

Patient Signature

Date

Name (if other than Patient)