

IMPORTANT: This form should be signed and sent by the patient to their physician(s) to obtain all of their medical records. The patient or their physician should then send these records, to:

Mailing Address: **The Institute for Healthy Aging**
Attn: Mark A. Rosenberg, M.D., FACEP
101 NW 1st Avenue, Delray Beach, Fl 33444

Dear Sir or Madam:

Your patient has requested entry to the Institute for Healthy Aging for evaluation and potential acceptance into our Integrative Cancer Treatment Program. This program requires a comprehensive pre-evaluation of the patient's health history and a full examination performed by our physicians.

Please provide us directly or through your patient with the following:

1. Copies of written reports:	2. Copies of case records to include:
a. Surgical Reports	a. Diagnosis
b. Pathology Reports	b. Location of primary tumor
c. X-ray Reports	c. Location of metastases
d. Scan Reports	d. Treatment procedures
e. Hematology Studies	e. Chemotherapy
f. Other	f. Radiation
	g. Surgery
	h. Other treatments

3. Complete Blood Count (CBC with differential, platelets) current taken within 14 days.

4. Blood Chemistry Panel (SMAC 22 or more) current taken within 14 days.

Follow up studies are imperative for evaluating patient progress and therapy. Please provide us with your evaluations and copies of the reports of all future studies.

If you have any questions, please call our information desk at:

The Institute for Healthy Aging
Breshan Nelson Office Manager
Telephone: 561 272 1956
Fax: 561 272 1992

Authorization to Use or Disclose My Health Information

To:	_____	_____
	<i>(Name of Practice)</i>	<i>(Personal Physician)</i>
Re:	_____	_____
	<i>(Patient Name)</i>	<i>(Date of Birth)</i>
	_____	_____
	<i>(Address)</i>	<i>(Phone Number)</i>

1. I hereby authorize you to release, disclose and deliver medical information described above regarding the above named patient to the Institute for Healthy Aging in care of Dr. Mark Rosenberg.
2. This authorization may be revoked by the undersigned at any time by giving written notice to the Institute. Any disclosure made prior to revocation in reliance upon this authorization shall not constitute a breach of rights of confidentiality of the patient. If not earlier revoked, this authorization will automatically expire once treatment is completed.
3. The Institute is not authorized to make any further release or disclosure of the information received. This authorization does not authorize the release or disclosure of any information except as provided herein.

Medical information may be released as provided in this authorization.

I request that a complete case report of my diagnosis, including all requisite medical and laboratory reports be prepared and be provided to The Institute for Healthy Aging. Furthermore, I hereby grant permission to access future medical records.

Patient or legally authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative, etc.)

NOTE: Please make copies of this form for records which may reside in several locations.

Health Information Rights

The health and billing records we maintain are the physical property of the office/hospital. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/hospital -- we are not required to grant the request, but we will comply with any request granted;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office/hospital;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office/hospital;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office/hospital. We may deny your request if you ask us to amend information that:
 - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
 - Is not part of the health information kept by or for the office/hospital;
 - Is not part of the information that you would be permitted to inspect and copy; or,
 - Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office/hospital;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office/hospital. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office/hospital, except to the extent information or action has already been taken.
- If you want to exercise any of the above rights, please contact Breshan Nelson, in person or in writing, during regular, business hours. She will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office/hospital is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact:

The Institute for Healthy Aging
Attention Breshan Nelson - Office Manager
Telephone - 561 272 1956

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Breshan Nelson, Office Manager. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services, whose street address and e-mail address is: Office for Civil Rights - U.S. Department of Health and Human Services - 200 Independence Avenue S.W. - Room 509F, HHH Building - Washington, D.C. 20201.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/hospital.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Directory

- Unless you notify us that you object, we will use and disclose your name, location, general condition, and religious affiliation in a hospital directory. This information may be provided to members of clergy and, except for religious affiliation, to other people who ask for you by name.

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

- We may use and disclose your protected health information to assist in disaster relief efforts.