Bluestone Physician Services - Authorization for Release of Health Information

Patient Information: *Please use full legal name*

Last Name: _____ First Name: _____ M.I. __ Date of Birth: __/__/_____

Community: _____

Release Information From *(Required):

Clinic Name: _____

Phone: _____

Fax: _____

Address: _____

_____

City: _____State: _____ Zip: _____

Release Information To:

☐ Bluestone Physician Services

Attn: Medical Records Dept.
270 Main Street N.
Suite 300
Stillwater, MN 55082

FAX: 855-490-4045
PHONE: 651-342-4275

Information To Be Released *(Required): *Indicate ONLY the information that you are authorizing to be released.*

☐ **ALL HEALTH INFORMATION** ☐ CD of Images ☐ Specific dates/years of treatment _____

OR Release Indicated Records only:

☐ History Form	☐ Doctor/Visit Notes	☐ Laboratory Reports	☐ Operative Reports
☐ Test Results	☐ ED/ER Records	☐ Hospital Records	☐ Discharge Summary
☐ Medication History	☐ Radiology Reports	☐ Therapy Notes	☐ Radiology Images
☐ Billing Statements	☐ Procedure Records	☐ Other Information/Instructions_____	

The following information requires special consent by law. Even if you indicate all health information, you must specifically request the following information in order for it to be released:

Chemical dependency program: Yes_____ No_____ Psychotherapy notes: Yes_____ No_____

I hereby authorize the release of my individually identifiable health information described above for treatment and payment purposes. I understand that this authorization to release health information is voluntary. I understand that the information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing of this form. I understand I may request a copy of this form after I sign it. I understand that this authorization may be revoked by me by written notice to Bluestone Physician Services. I understand that if I revoke this authorization it will not have any effect on any actions taken by Bluestone Physician Services before receiving my revocation. This release covers past, present and future encounters/visits unless I write in specific treatment dates here: _____ to _____. This consent will expire one year from the date it is signed unless I write in a specific expiration date here: _____.

_____ _____

Patient or Legal Representative Signature **Date**

_____

Legal Representative Printed Name and Authority to sign for patient (i.e. Health Care Directive, Medical POA –*must include documentation)*

Fax Completed Forms To: **MN**: 855-306-1167 **WI**: 888-972-8297 **FL**: 855-523-3935

Bluestone Physician Services
Consent for Services and Insurance HIPAA Acknowledgement

Patient's Full Name: _____ **Date of Birth:** ___ / ___ / _____

Community: _____

Consent for Services and Disclosure of Information for Treatment: I consent to evaluation and treatment services determined by the physicians, nurses, or designees of Bluestone to be necessary or advisable. I also consent to the use and disclosure of my health information by Bluestone for my treatment, including disclosure of my health care information to health care providers and facilities unrelated to Bluestone that may be involved in my care. Bluestone may disclose my health information to and access my health information from other providers using a record locator service or patient information service of a health information exchange for treatment unless I object by checking here: ❑

Notice of Privacy Practices and Consent: I acknowledge I have received a copy of Bluestone's Notice of Privacy Practices and I understand that I have a right to review these privacy practices before signing this consent form. I understand that Bluestone may change its privacy practices in the future, that any changes will be posted on Bluestone's website, and that I may request a copy of the new privacy practices at any time. I also understand that I can contact Bluestone's Privacy Officer with any questions I may have about the Notice of Privacy Practices. In addition to the other uses and disclosures described in this document, I consent to the use and disclosure of my health information for the purposes described in the Notice of Privacy Practices, including Bluestone's health care operations.

Insurance Assignment and Payment Consent: I authorize payments directly to Bluestone of insurance, Medicare or Medical Assistance benefits, or funds from other sources I am entitled to receive as payment for services provided to me. I consent to the use and disclose my health information for payment purposes. Also, my insurer may share my past, current, and future health and account records with Bluestone about services received from Bluestone and care providers unrelated to Bluestone. These records may be used by Bluestone as needed to manage, coordinate, and to improve the quality of my care. **If I do not agree, I will check the box below.**
❑ My insurer may not release health information from providers unrelated to Bluestone for the purposes described above.

Use of Health Care Records in Program Evaluations and Training: I give Bluestone permission to use and disclose information gathered during the course of my treatment from Bluestone, including information from my treatment records, for the purposes of program evaluation and training and for quality review of the staff performance at Bluestone.

Patient Centered Medical Home and Chronic Care Management: I give Bluestone permission to enroll me in the Bluestone Program, which includes appropriate physician/care management visits and activities, which will be billed to my insurance with normal deductibles and copays. I understand information on these programs is included in the enrollment information and on the Bluestone website.

Consent for Use of Medical Records in Academic Research: I authorize Bluestone Physician Services to use or disclose my health records for medical or academic research, including health records created at any time by Bluestone and records Bluestone received from other health care providers, unless I object by checking here: ❑ At my request, Bluestone will tell me the dates on which my health records are released for research and tell me how to contact external researchers who have received my records.

Family/Patient Bluestone Bridge and Patient Portal Access: I (circle one) **have/have not** submitted a copy of a Health Care Directive, Medical Power of Attorney, Guardianship, or other signed authorization giving another person power to authorize the use and disclosure of my health information. If I have submitted this type of authorization, I authorize my representative to communicate with my Bluestone Provider Team electronically through the use of the Bluestone Bridge and/or the Bluestone Patient Portal. See Bridge Enrollment Form to add additional Bridge users. Call the Bridge Help Desk with questions: 855-794-9476.

This consent applies to health information that Bluestone already has about me, information about future care I may receive from Bluestone, and information Bluestone receives from third parties. This consent will continue unless I cancel by giving written notice to Bluestone Physician Services or it expires as required by law. Cancellation will apply only *after the date* when the notice to cancel is received. It will not affect information that was used or disclosed before the cancellation.

Patient's Signature (or legal representative) Date

Note: *This consent must be signed by the patient, unless the patient is mentally or physically unable to sign.*

E-Mail Address:

❑ *No Email Address* ❑*Do not want access to the Bluestone Bridge or Patient Portal at this time*

(Legal representative - Relationship to client) ❑Physical or mental disability ❑ Other

***Fax Completed Forms To*:** **MN**: 855-306-1167 **WI**: 888-972-8297 **FL**: 855-523-3935

Notice of Privacy Practices

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.

Your Health Information and Our Privacy Commitment to You

Bluestone keeps records of your visits with our providers. Usually, this record includes your name, date of birth, sex, financial information, insurance information and other personal information, such as problems you are facing with your health or in your life and your goals for solving these. This information is called your health information.

We care about your privacy. Only people who have both the need and the legal right may have access to your health information without your authorization. Unless you give us permission in writing, we will only use or disclose your health information for purposes of treatment, payment, and health care operations or for the other purposes described below. Where appropriate, we use or disclose only the health information that is minimally necessary to accomplish the intended purpose.

Our Legal Duty

We are required by law to protect the privacy and security of your health care information, to provide this notice about our information practices, to follow the information practices that are described in this notice, to accommodate reasonable requests you may have to communicate health information, and to notify you if we are unable to agree with a request.

We are also required by law to obtain your signed acknowledgment of receiving this notice. Please know that you can refuse to acknowledge receipt of this notice and still receive treatment from Bluestone providers. The privacy practices described in this form will still be followed. You will not be treated differently.

We may change our privacy practices at any time and our new practices will apply to all health information we hold. Before we make a significant change, we will change this notice and post the new notice on the Bluestone website and at its offices. You can also request a copy of this notice at any time through your Bluestone provider. If you have any questions or would like more information about our privacy practices, please ask your Bluestone health care provider.

Uses and Disclosures of Your Health Information

Treatment

We can use and disclose health information about you to provide you with treatment or services. We may disclose health information about you to health care providers, interns, volunteers, and interpreters for treatment. For example, your treatment team members will discuss your health information in order to develop and carry out a plan of care.

Payment

We can use or disclose health information about you to obtain payment for treatment and services. For example, we may disclose your health information to bill insurers. We may also tell your health plan about a treatment or medication you are going to receive to obtain prior approval or to determine if your plan will cover it.

Health Care Operations

We can use or disclose health information about you for our health care operations and the health care operations of certain other entities. For example, this may include reviewing our clients' health information to evaluate the quality of the treatment and services we provide and to evaluate our staff.

Psychotherapy Notes

Under most circumstances, without your written authorization, we may not disclose the psychotherapy notes a mental health professional took during a counseling session.

HLTV-III Test

If we perform the HLTV-III test on you (to determine if you have been exposed to HIV), we will not disclose the results of the test to anyone but you without your written consent unless otherwise required by law. We also will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

Deceased Individuals

Following your death, we may disclose health information to a coroner or to a medical examiner as necessary for them to carry out their duties and to funeral directors as authorized by law. In addition, we may disclose health information to your next of kin or a personal representative (for example, the executor of your estate).

Health Care Agent - Guardian

If you have a legal guardian, have appointed a health care agent, or have another legally authorized personal representative, we will treat that person as if that person is you with respect to uses and disclosures of your health information.

Appointments

Your health information will be shared with our administrative staff so they may contact you to make appointments or remind you of appointments. You may request that we provide such reminders only in a certain way or only at a certain place. We will try to accommodate all reasonable requests.

Research

We may use and disclose your health information for reviews preparatory to research and for research studies if approved by a privacy board or institutional review board. You may ask us how to contact a researcher to whom your information was disclosed for research and the date of disclosure.

Business Associates

Bluestone sometimes contracts with third-party business associates for services, such as billing or consulting services. We may disclose your health information to our business associates so that they can perform the job we have asked them to do.

Release to Family/Friends

Our health professionals, using their professional judgment, may disclose your health information to a family member, friend, or any other person who is involved in your care or payment for your care. We will provide you with an opportunity to object to such a disclosure whenever we practicably can do so.

Health Information Exchange

We may participate in one or more electronic health information exchanges, record locators, or patient information services, which permit us to exchange health information about you with other participating providers and their vendors. For example, we may permit a physician providing care to you to access our records in order to have current information to treat you. The requesting provider must verify that they have or have had a treatment relationship with you, and, if required by law, we will ask the provider to obtain your consent before accessing your health information through the health information exchange.

Fundraising

We may contact you or have our foundation contact you for fundraising purposes. We will limit our use and disclosure to your demographic information, such as age and address, the dates you received care, and other limited information about your care. Our fundraising materials will tell you how to opt out of receiving future fundraising communications.

Future Communications

We may use your medical information to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may provide you information by a general newsletter or in person or by way of products or services of nominal value.

When We Use or Disclose Your Personal Information with Your Permission

In some situations, we may be required by State law to obtain your written consent in order to share your personal information with nonaffiliated people or organizations for treatment, payment or health care operations.

Other Circumstances Where Your Health Information May be Used or Disclosed

Subject to certain requirements, we may use or disclose your health information without your authorization for public health purposes, such as reporting disease; auditing purposes; emergencies; health oversight activities; military and national security; workplace and medical surveillance; law enforcement; legal process, and judicial and administrative actions; government investigation; and reporting abuse and neglect of vulnerable adults. We may disclose your information for these purposes to the Food and Drug Administration, the Department of Health and Human Services, correctional facilities, and other government agencies.

We also may disclose your health information when permitted or required by federal, state or local law. For example, in limited specific circumstances, we may disclose health information to protect your safety and that of others.

Except as noted above, we will ask for your written authorization before using or disclosing any identifiable information about you. If you sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures without penalty of any kind.

We will not sell your health information or use or disclose it for marketing purposes without your authorization.

Individual Rights

You have the following rights with respect to your health information.

Right to Review and Copy your Personal Information

We maintain a designated record set of our patients' medical records, billing records and other records used to

make decisions about our patients and their care. You have a right to inspect and obtain a copy of your personal information that we maintain in this designated record set. If the designated record set is maintained in an Electronic Health Record, you may request a copy of your personal information in electronic format. We reserve the right to determine the format. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial is reviewed.

Right to Request an Amendment of Your Personal Information

If you feel the medical information we have about you is incorrect or incomplete, you have the right to request an amendment of your personal information in our designated record set. We will consider your request, but we are not required to agree to your changes.

Right to Restrict Disclosures to Health Plans

You have the right to prohibit us from disclosing to your health plan personal information related to a particular service, if you pay us for that service in full and if the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law.

Right to Request Other Restrictions of Your Personal Information

You have the right to ask us not to use or disclose your personal information for any of the purposes described in this notice. We will consider your request, but we are not required to agree to your request.

Right to Request Confidential Communications

You have the right to ask us to communicate with you about confidential matters by alternative means or at alternative locations. We will make reasonable efforts to accommodate your request.

Right to Receive an Accounting of Disclosures

Subject to certain exceptions, you have the right to receive from us an accounting, or listing, of instances when we released your personal information to nonaffiliated third parties.

Right to Obtain a Copy of this Notice

You can request an additional copy of this notice using the Contact Information below. This notice is also available on our website:

www.bluestonemd.com

Right to Complain about Our Privacy Practices

If you believe we have violated your privacy rights, you may complain to us directly (see Contact Information below) or to the Office for Civil Rights of the United States Department of Health and Human Services. You may file a complaint with either us or the Office for Civil Rights without fear of reprisal.

Right to Receive Notice of a Breach

We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach.

For More Information or to Report a Problem

For more information or to report a problem you may contact any of Bluestone's providers. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you can file a complaint with Bluestone's Privacy Officer in person or by phone at:

Privacy Officer
Bluestone Physician Services
270 North Main Street, Suite 300
Stillwater, MN 55082-6788
Phone: 651-342-4276

You will not be treated differently if you make a complaint.

You may also file a complaint with:

Region V Office for Civil Rights
US Department of Health and Human Services
233 N. Michigan Ave, Ste. 240
Chicago, IL 60601
Voice Phone: 312-886-2359
Fax: 312-886-1807
TDD Phone: 312-353-5693

You will not be penalized for filing a complaint with the federal government.

The effective date of this notice is July 20, 2016.

Bluestone Physician Services - Patient Enrollment Form

Patient Name/Information: *Please use full legal name*

Last: _____ First: _____ MI: ___ D.O.B.: ___ / ___ / ___ ☐ M ☐ F

Community: _____ ☐ Memory Care ☐ Assisted Living

Social Security: _____-_____-_____ Medications Managed By: ☐ Community Staff ☐ Family/Caregiver ☐ Self/Patient

Race/Ethnicity: *Choose one or more* ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐Native Hawaiian/Other Pacific Islander ☐ White ☐ Declined ☐ Unknown

Primary Language: _____ Country of Origin: _____
☐ Interpreter Services Needed

Insurance Information: Medicare ID #:_____

Primary Plan Name: _____

Primary Policy ID #:_____ Primary Group #:_____

Secondary Plan Name: _____

Secondary Policy ID #:_____ Secondary Group #:_____

Healthcare Decision Maker: *Provide copy of Health Care Directive, Medical POA, or Guardianship*

☐ *No Legal Representative, Health Care Directive or Medical POA*

Name: _____ Relationship to Patient: _____

Primary Phone#:_____ Secondary Phone #:_____

Address: _____ City: _____ State: _____ Zip: _____

E-Mail Address: _____

Billing Contact: ☐ *Same as Healthcare Decision Maker*

Name: _____ Relationship to Patient: _____

Primary Phone#:_____ Secondary Phone #:_____

Address: _____ City: _____ State: _____ Zip: _____

Allergies: *List specific reactions*

_____

Bluestone Physician Services – Patient Health History Form

Last: _____ First: _____ MI: ___ D.O.B.: ___ / ___ / _____

Community: _____

Provide a Copy of Current Medication List and Dosages

Current Diagnosis:	
☐ Alzheimer's / dementia:	☐ Glaucoma:
☐ Arthritis / osteoporosis /rheumatoid arthritis:	☐ Heart Disease:
☐ Asthma / COPD:	☐ Hypertension:
☐ Cancer:	☐ Incontinence:
☐ Chronic Kidney Disease:	☐ Lung Disease:
☐ Depression / Mental Health Conditions:	☐ Parkinson's Disease:
☐ Diabetes:	☐ Stroke/CVA:
☐ Other:	
Family History: *Specify relationship to patient*	
☐ Alzheimer's/Dementia:	☐ Heart Disease:
☐ Cancer -Type:	☐ Hypertension:
☐ Diabetes:	☐ Other:
☐ Depression / Mental Health Conditions:	
Previous Surgeries or Recent Hospitalizations: *Provide approximate dates*	
Advance Directive / Advance Care Plan:	
☐ Yes, I have an Advance Directive/Advance Care Plan *(Please include copy)*	☐ No, would like more information
Immunizations: *Provide last approximate date/year*	
Pneumonia:	Flu:
Shingles:	Tetanus:
Tobacco History:	
☐ Non-Tobacco User	☐ Exposure to Second-Hand Smoke
☐ Former Tobacco User	☐ Current Tobacco user
Last Specialty Evaluations: *Provide last approximate date and provider name*	
Dental:	Provider:
Vision:	Provider:
Hearing:	Provider:
Last Colonoscopy/Sigmoidoscopy:	Provider:
Last Mammogram:	Provider:
Other Specialty Providers that follow you:	

☐ In the event of a specialty referral, I would like the Bluestone Referral Coordinator to contact my Medical (long-form) POA:

Name: _____ Relationship: _____ Phone: _____

Fax Completed Forms To: **MN**: 855-306-1167 **WI**: 888-972-8297 **FL**: 855-523-3935

BLUESTONE RESIDENTIAL CARE PROGRAM
Patient Centered Medical Home & Chronic Care Management

Bluestone Physician Services is a unique care model for people living in residential settings who benefit from care services provided by residential care staff.

"Patient Centered Medical Home" is an approach to primary care in which primary care providers, families, and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities through regular, evidence-based preventative care. Medicare expanded this approach in 2015 to include "Chronic Care Management." The legislation includes payment to primary care providers for partnering with patients and families to provide coordination of care. This benefit of coordinated care is covered by your Medicare/Medicaid plan with copays, if normally incurred.

Patient Centered Medical Home & Chronic Care Management is a way of delivering health care. It is not a building, house, hospital, or home care. Rather, it is a team approach to care that gives you access to all the services and support you need. That team includes you (the patient), your primary care provider, other health care providers, and other staff who can help in your care. Care coordination is provided for all Bluestone patients.

Benefits of Patient Centered Medical Home, Chronic Care Management, & Care Coordination:

- Care is focused on you as a whole person, not just one part or problem
- Coordinated care that is tailored to fit your needs
- Increased access to your care team, both during and after office hours through the use of Bluestone Bridge, and the Bluestone Patient Portal
- Patient education on medications and disease management available at **www.BluestoneMD.com**, and through your personal health record located on the Bluestone Patient Portal
- Assistance with securing durable medical equipment
- Support with Advance Care Planning and end of life discussions
- Coordination of care for management of transitions across multiple settings
- Coordination with other specialists and help connecting you to other healthcare services, support networks, and community services
- Access to behavioral health services, as needed
- Your provider team will work collaboratively with your entire care team, including the community nursing staff where you live

When you enroll with Bluestone Physician Services, you will have the benefits of Patient Centered Medical Home and Chronic Care Management. To enroll in the program sign the *Consent for Services/ HIPAA Acknowledgement* form and return to:

MINNESOTA/WISCONSIN
Bluestone Physician Services
270 Main Street North
Suite 300
Stillwater, MN 55082
FAX: 855-306-1167

FLORIDA
Bluestone Physician Services
10150 Highland Manor Drive
Suite 240
Tampa, FL 33610
FAX: 855-523-3935

Office Hours:
Monday – Thursday: 8:00 AM – 5:00 PM
Friday 8:00 AM – 3:00 PM

Bluestone Physician Services

To enroll residents in the Bluestone on-site care program, fax completed forms to the Bluestone office

REQUIRED

- ☐ **Patient Enrollment Form with Community Face Sheet**
- ☐ **Health Insurance Information**
- ☐ **Consent for Services and Insurance – HIPAA Acknowledgement *(completed by Patient/POA)***
- ☐ **Medical Power of Attorney, Health Care Directive or Guardianship paperwork (*required if activated)***

**Required in order for us to share information via the Bluestone Bridge communication portal*

WHEN AVAILABLE

- ☐ **Recent visit note or hospital discharge summary**
- ☐ **Copy of patient's most current medication list**
- ☐ **Authorization to Release Protected Health Information Form *(completed by Patient/POA)***
- ☐ **Bluestone Bridge Registration Form *(completed by Patient/POA)***

Fax or mail completed forms to:

MINNESOTA/WISCONSIN
Bluestone Physician Services
270 Main Street North
Suite 300
Stillwater, MN 55082
FAX: 855-306-1167

FLORIDA
Bluestone Physician Services
10150 Highland Manor Drive
Suite 240
Tampa, FL 33610
FAX: 855-523-3935

Please allow 4 business days for processing of enrollment paperwork prior to first appointment.
Enrollment paperwork required to be completed and received by Bluestone prior to new patients being enrolled.

www.BluestoneMD.com