Bay Area Chest Physicians

HIPAA Release Form

Name: _____ Date of Birth: ___/___/___

Today's Date: ___/___/___

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 me in writing.

Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorizes Bay Area Chest Physicians to review my external prescription history.

By signing this consent form you are agreeing that your provider at Bay Area Chest Physicians may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Print Patient Name: _____ Date of Birth: ___/___/___

Signature of Patient or Guardian: _____
Date Signed: ___/___/___

Relationship to Patient: _____

Bay Area Chest Physicians

Please fill out the sections below to help us with your medical management.

Name:_____ DOB:_____

Referring Dr:_____ Primary Care Dr:_____

List Medications & Supplements You Take: (attach list if necessary)

Medication	Dose	Frequency

List Any Medications You Are Allergic to:

Medication you are allergic to	**Reaction to that medication**

List Any Personal Cancer History You Have Had:

Location & Type	**Year of Diagnosis**

Social History:	**Vaccine History:**
Are you a Current Smoker Y N Packs a day #	Year of last Flu Vaccine
Are you a Former Smoker Y N Packs a day #	Year of last pneumonia Vaccine
Age you started Age you Quit	# Covid vaccines have you had
Vape or E-Cigs Y N	
Do you smoke, vape or use Marijuana Y N	
Exposure to Asbestosis Y N Coal Dust Y N	

Name:_____

Have you had any of the following?

Medical History:	Response:	Surgical History:	Year:
Covid-19	Y or N	List any surgery you have had	Document year of Surgery
Pneumonia	Y or N		
Bronchitis	Y or N		
Asthma	Y or N		
TB	Y or N		
COPD	Y or N		
Emphysema	Y or N		
Pulmonary Fibrosis	Y or N		
Bronchiectasis	Y or N		
MAC	Y or N		
Pulmonary Hypertension	Y or N		
Lung Cancer	Y or N		
Pulmonary Embolism	Y or N		
Pleural Effusion	Y or N		
Sjogren's Syndrome	Y or N		
Scleroderma	Y or N		
Muscular Dystrophy	Y or N		
Cystic Fibrosis	Y or N		
Raynaud's Syndrome	Y or N		
Sleep Apnea Using Pap Device	Y or N Y or N	**Family HX:**	Age of death, any major health conditions and cause of death:
Narcolepsy	Y or N	Father: Alive or Deceased	
Insomnia	Y or N	Mother: Alive or Deceased	
Hypertension	Y or N	Sibling: Alive or Deceased	
Coronary Artery Disease	Y or N	Children: Alive or Deceased	
Congestive Heart Failure	Y or N	G.Parents: Alive or Deceased	
Atrial Fib	Y or N		
Pacemaker	Y or N		
DVT	Y or N		
High Cholesterol	Y or N		
GERD	Y or N		
Ulcers	Y or N		
Diabetes	Y or N		
Thyroid Disease	Y or N		
Lupus	Y or N		
Myasthenia Gravis	Y or N		
ALS	Y or N		
Stroke or TIA	Y or N		
Seizures	Y or N		
Arthritis RA or Osteo	Y or N		

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME **DATE**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Bay Area Chest Physicians may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Bay Area Chest Physicians has a detailed document called the **'Notice of Privacy Practices'**. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Bay Area Chest Physicians will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Bay Area Chest Physicians to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Bay Area Chest Physicians has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

Relationship to Patient if signed by another party **DATE**

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting: Bay Area Chest Physicians 430 Morton Plant St Suite 405 Clearwater, FL 33756 Attn: HIPAA Representative.

FORM Us

BAY AREA CHEST PHYSICIANS

Consent for AI Recording and Charting of Patient Encounter

PURPOSE OF CONSENT

Your healthcare provider may use advanced technology to enhance the quality and accuracy of your medical records. This may include recording your visit and utilizing artificial intelligence (AI) to scribe and chart the details of your encounter into our electronic medical record (EMR) system. If your healthcare provider utilizes AI tools, the following terms apply:

WHAT THIS MEANS

1. **Recording of Your Encounter:**
   - Your conversation with the healthcare provider may be recorded during your visit.
   - The recording will capture all verbal communication between you and your healthcare provider.
2. **Use of AI Technology:**
   - The recorded conversation will be processed by AI technology to generate accurate and detailed notes of your medical encounter.
   - The AI technology will assist in documenting your symptoms, medical history, treatment plans, and other relevant information.
3. **Confidentiality and Security:**
   - The recording and all processed information will be kept confidential and secure, in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
   - Only authorized personnel will have access to your recorded and processed information.
4. **Your Rights:**
   - You have the right to ask questions about this process and how your information will be used.
   - You have the right to refuse the recording and use of AI technology. If you choose not to consent, it will not affect the quality of care you receive.

CONSENT

By signing below, you acknowledge that you have read and understood the information provided. You voluntarily consent to the potential recording of your medical encounter and the use of AI technology to scribe and chart the details into our EMR system.

Patient Name: _____

Patient Signature: _____

Date: _____

If you have any questions or concerns about this process, please feel free to let our staff or your healthcare provider know. We will be happy to address any of your related concerns.

EPWORTH SLEEPINESS SCALE

Name: _____

Date: _____

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired?

Use the following Scale to choose the most appropriate number for each situation:

0- Would never doze
1- Slight chance of dozing
2- Moderate chance of dozing
3- High chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and Reading	_____
Watching Television	_____
Sitting inactive in a public place Such as a theater or meeting.	_____
As a passenger in a car for an hr Without a break.	_____
Laying down to rest in the afternoon When circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes In traffic.	_____
Add ALL Responses	Total _____

SCORES

1-6	Getting enough sleep
7-8	Score is average
9 and up	Excessively Sleepy- Seek the advice of a sleep specialist without delay