HIPAA Consent

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations, Per HIPAA Regulations

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine health care operation, such as assessing quality and reviewing the competence of staff

I have been provided with a "Notice of Patient Privacy Practices" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the "Notice" prior to acknowledging this consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health operations

Restrictions

I request the following restrictions to the use or disclosure of my health information: _____

_____

Tell us with whom we may discuss your protected health information: (Name and relation - Example: Jane Doe, Wife; Jan Doe, Daughter) _____

Messages or Appointment Reminders

Messages will be of a non-sensitive nature, such as, appointment reminders.

May we leave a message at your home using doctor's/practice name? ❑ Yes ❑ No

May we leave a message at your work using doctor's/practice name? ❑ Yes ❑ No

I understand that as part of treatment, payment or health care operations, it may become necessary to disclose health information to another entity, e.g. referrals to other health care providers. I consent to such disclosure for these uses as permitted by law. I fully understand and accept/decline (circle one) the information of this consent.

Notice of Privacy Practices

I acknowledge that I have been provided with the Practices' Notice of Privacy Practices that provides a description of Protected Health Information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this statement. I understand that the Practice reserves the right to change its Notice of Privacy Practices that will be effective for health information the Practice already has about me, as well as any they receive in the future. The Practice will post a current copy of the Notice. I understand that I may obtain a copy of the current Notice in effect upon request. I have read all of the above and understand/agree to all provisions therein regarding responsibility for payment, permission for treatment and Notice of Privacy Practices.

_____ _____

Patient/guardian signature Date

_____

Print name of person signing

If other than the patient (patient name) _____ is signing, are you the legal guardian, custodian, or have Power of Attorney for this patient, for treatment, payment or health care operations? ❑ Yes ❑ No

BayCare Medical Group