H.I.P.P.A

Health Information Privacy Practices Acknowledgement

Patient consent to the use, disclosure and request of health information for treatment, payment, or health care operations

Patient name:_____ Date:_____

As part of your health care, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnosis, treatment and any plans for future care or treatment. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals who contribute to your care
- Submit your diagnosis and treatment information for payment from insurance companies or others

By signing this document, and "*only as permitted by State or Federal law"*, you are giving this practice your consent to do the following:

- Disclose, as may be necessary, your health information to other health care providers (such as, referrals to or consultation with, other health care professionals, laboratories, hospitals, etc.) for your treatment or health care.
- Request from other health care entities specific health care information we may need for planning your care and treatment.
- Submit your diagnosis and treatment information to insurance companies, other agencies or individuals for payment of services.
- Leave appointment reminders or information, we believe necessary for treatment or payment, with a family member or on an answering machine.
- Discuss your information (only as necessary in our judgement) with family members or other persons who are or may be involved with your health care treatment or payments.
- Please list by name and relationship **any person with whom we may not share your health or payment information** (based on professional judgement, this practice has the right not to honor your request)._____

We will make available to you our "*Notice of Patient Privacy Practices"* that provides a more complete description of health information uses and disclosures as required by the HIPPA standard. You have the following rights:

- The right to read the "*Patient Privacy Practices"* prior to signing this consent.
- The right to request a copy of the "Patient Privacy Practices" for your own personal use.

I fully understand and agree to this consent and acknowledge the above rights and disclosures.

_____ _____

Signature of patient or parent/guardian if under 18 years old Date

FOR OFFICE USE ONLY:

- Consent form reviewed by(employee)_____
- Patient refused to sign the consent form. Reason for refusal_____
- Restrictions added by the patient (see restrictions above)