



## **PATIENT HIPAA CONSENT FORM**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This provides a safeguard to my privacy.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional services and care. Additional information is available from the U.S. Department of Health and Human Services. [www.hhs.gov](http://www.hhs.gov)

We have adopted the following policies:

1. Patient Information will be kept confidential except as necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient record, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to the PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to confirm your request.

I, \_\_\_\_\_, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature of Patient or Guardian \_\_\_\_\_

Date: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. The Notice takes effect immediately and will remain in effect until we replace it.

We reserve the right to change our privacy practice and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessments and improvement activities reviewing the competence or qualifications of healthcare professionals evaluating practitioners and provider performance conducting training programs, accreditation, certification licensing or credentialing activities.

**Your Authorization:** In addition to our use of your healthcare information for treatment payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization you may revoke it in writing at any time. Your

revocation will not affect any use or disclosure your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare but only if you agree that we may do so.

Persons Involved in Case: We may use or disclose health information to notify or assist in the notification.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

#### QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to request you made to amend or restrict the use or disclose of health information or to have us communicate with you by alternative means or at alternative locations you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services upon request.

**By signing below, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form. We support your right to the privacy for your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.**

**Signature of Patient or Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_