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HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form outlines some of those policies and requests your consent regarding how we may convey information to you and others so as to serve you better. The practice's complete Notice of Privacy Practices (NPP), which we have either given to you before or with this form, is posted in the office and available upon request. You should review the NPP prior to signing this consent.

We have adopted the following policies and we request your consent for the following actions:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. HIPAA refers to this as treatment, payment and operations (TPO). This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as well as other parties necessary for TPO. TPO is more thoroughly described in the NPP. By signing this consent, you acknowledge receipt of our NPP and agree that we may share your personal health information (PHI) for purposes of TPO.

2. It is the policy of this office to remind the patients of their appointments. We may do this by telephone message, unencrypted e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. By signing this consent, you agree that we may contact you in this manner with the following exceptions (no exceptions if left blank):

3. Please check which of the means below you would like us to use to provide you with medical information regarding your care:

- ☐ Home voicemessage . . . .Tel. number _____
- ☐ Work voicemail . . . . . Tel. number _____
- ☐ Cellphone voicemail . . . .Tel. number _____
- ☐ Facsimile . . . . . .Tel. number _____
- ☐ Unencrypted e-mail . . .. . e-mail address _____
- ☐ Home address: _____
- ☐ Other mailing address: _____

4. Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? CHECK ALL THAT APPLY.

- ☐ Spouse: ___ Tel. number _____
- ☐ Caretaker: _____ Tel. number _____
- ☐ Child: _____ Tel. number _____
- ☐ Parent: _____ Tel. number _____
- ☐ Other: _____ Tel. number _____

5. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the confidentiality rules of HIPAA.
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 and the NPP in accordance with HIPAA regulations.
9. You have the right to request additional restrictions in the use of your PHI, although we are not obligated to do so and we will advise you accordingly.

I do hereby consent and acknowledge my agreement to the terms set forth in this HIPAA INFORMATION AND CONSENT FORM I understand that this consent shall remain in force from this time forward unless I withdraw my consent in writing, except to the extent that the practice has taken action in reliance upon my prior consent.

Patient Name (Print) _____ Date_____
Signature: _____

Guardian name (Print) _____ Guardian's signature: _____
Relationship to patient: _____