

Personal Representative Authorization Form

I authorize this facility to speak to the following family members or my personal representative regarding:

All medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes and any other non-medical information in my file.

Only the following types of information:

The above medical information shall only be released to the following persons:

Family Member/Personal Representative

Relationship:

I understand that I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and effective date.

This authorization shall remain valid (check one)

- Until revoked in writing.
- Until _____, 20_____

I know that I am entitled to receive a copy of this agreement.

Name _____

Signature _____

Signed this _____ day of _____ 20_____

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of receipt of information Practices Notice (§164.520(a))

I, _____ (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information.

I understand that:

- I have the right to review this facility's **Notice of Privacy Practices** prior to signing this acknowledgement;
- This facility reserves the right to change their **Notice of Privacy Practices** and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness _____

Printed name of Individual or Legal Representative _____

Witness _____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain a written acknowledgement of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Others (please specify)

HIPAA Officer _____

Date: _____

HIPAA Privacy Rule Receipt of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____ (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, 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 may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the **Notice of Privacy Practices**, that provides a more complete description of information uses and disclosures. I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's **Notice of Privacy Practices**, prior to signing this consent;
- This facility reserves the right to change their **Notice of Privacy Practices** and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient or Legal Representative

Witness _____

Printed name of Patient or Legal Representative

Witness _____

Date: _____