HIPAA and Consent Form

ID _____

Notice of Privacy Practices

Our office provides a copy of our Privacy Practices upon the first visit for new patients. We also post copies around the office for patient access.

☐ I have been provided and have reviewed the Notice of Privacy Practices of this office

Patient Portal

The Patient Portal Application Programming Interface (API) provided by our office is an online service of no charge to the patient which allows for seamless electronic communication of Patient Health and Financial Records using a certified secure environment. Activation of the Patient Portal requires the patient to provide a personal email address.

Patient Portal Access (select the best option)

☐ NO, I would not like access, please Opt Out

☐ YES, I would like access with this email address: _____

(If you already have access, please select YES and write the email that has access so we may confirm we have the correct information. Select NO to change your access to opt out.)

Contact Info

Our office will sometimes need to contact the patient via telephone with information regarding appointments and medical concerns. We will only attempt to call the patient at phone numbers approved by the patient, and we will only leave a detailed message if the patient gives consent.

My Contact Number *required*

( ) - ☐ Mobile ☐ Home ☐ Work

☐ NO, Don't leave a message

☐ YES, you may leave a detailed message

Other Contact *optional*

Name:_____

Relationship:_____

( ) - ☐ Mobile ☐ Home ☐ Work

☐ Release Medical Info ☐ Release Financial Info

Other Contact *optional*

Name:_____

Relationship:_____

( ) - ☐ Mobile ☐ Home ☐ Work

☐ Release Medical Info ☐ Release Financial Info

Other Contact *optional*

Name:_____

Relationship:_____

( ) - ☐ Mobile ☐ Home ☐ Work

☐ Release Medical Info ☐ Release Financial Info

Medical Imaging

Our office may use medical imaging (photo, video, and/or audio) in a patient's record to assist with demographic identification and/or clinical assessment. The patient will not receive payment from any party. Refusal to consent to medical imaging will in no way affect medical treatment.

Medical Imaging Consent (select the best option)

☐ NO, I do not consent to the usage of my image in my PHI

☐ YES, I consent to the usage of my image in my PHI

PDMP Acknowledgment

Under the Texas House Bill No. 2561, our office is required to access patient prescription history, which may include prescription details not originating from our office, before prescribing or dispensing controlled substances.

☐ I understand my doctor's obligation to access my prescription history when prescribing controlled substances

I understand I have the right to revoke this authorization at any time and that my revocation must be in writing. I am aware my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have already acted in reliance upon this authorization.

Printed Name: _____

Signature: _____ Date: _____