**North Franklin Internal Medicine & Pediatrics**

**HIPAA Compliance Form**

In accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act (HIPAA), in order for your physician or the staff of **North Franklin Internal Medicine & Pediatrics (NFIMP)** to give copies of and/or discuss your condition, exams, procedures, or x-rays with members of your family or other individuals that you designate other than your primary care doctor or specialist, we must obtain your authorization prior to doing so. We must also obtain your authorization to discuss financial information with members of your family or other individuals that you designate other than insurance companies or third party payers and their agents. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

I authorize NFIMP to communicate with me by any means I provide. I also authorize NFIMP to share my information with the following individuals:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize NFIMP to communicate with only me by any means I provide.

I DO NOT authorize NFIMP to communicate with me by any means other than in person, by phone, or via the portal. I acknowledge by choosing this option it may delay care and thereby adversely affect the quality of my care.

**Medication Access Authorization**

I authorize NFIMP to obtain/download medication information from my pharmacy via Surescripts.

I DO NOT authorize NFIMP to obtain/download medication information from my pharmacy via Surescripts. I acknowledge by choosing this option it may delay care and thereby adversely affect the quality of my care.

**Immunization Access Authorization**

I authorize NFIMP to download or update my immunization information to the Tennessee Department of Health Immunization Registry.

I DO NOT authorize NFIMP to download or update my immunization information to the Tennessee

Department of Health Immunization Registry.

**I acknowledge receipt of the Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act about how NFIMP may use and disclose my protected health information. I understand that NFIMP reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me.**

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Signature of Patient/Guardian Date Signed