**Cool Springs 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 **Cool Springs Internal Medicine & Pediatrics (CSIMP)** 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 CSIMP to communicate with me by any means I provide. I also authorize CSIMP to share my information with the following individuals:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

I DO NOT authorize CSIMP 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 CSIMP to obtain/download medication information from my pharmacy via Surescripts.

I DO NOT authorize CSIMP 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 CSIMP to download or update my immunization information to the Tennessee Department of

Health Immunization Registry.

I DO NOT authorize CSIMP 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 CSIMP may use and disclose my protected health information. I understand that CSIMP 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