HIPAA CONSENT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

PATIENT AKNOWLEDGEMENT AND CONSENT FORM.
Our handout "We Care about Your privacy" provides information about how Rockville Gynecology may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).
Our "We Care about Your Privacy" notice states that we reserve the right to change terms described. Should this happen we will display the new policy and effective date.

You have the right to request restrictions on the use and disclosure of your medical records/ information; however, the provider is not required to agree to restrictions not guaranteed by law. You will be informed if Rockville Gynecology does not agree to your requested restrictions.

By signing below, you acknowledge receipt of our "We Care about Your Privacy".

____ ____ _____________
Print Patient Name **Signature** **Date**

CONSENT FOR USE AND DISCLOSURE OF INFORMATION
By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except, where we have already made disclosures in trust on your prior consent.

I request that payment of authorized medical insurance carrier benefits be made on my behalf to Rockville Gynecology for any services furnished to me by my physician. I authorize any holder of medical information about me to release to Rockville Gynecology/agent and or any other insurance carriers for which I have coverage, any information needed to determine these benefits or the benefits related services. I agree to provide all reference and treatment plan(s) as require by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted insurance carrier agreements.

____ ____ _____________
Print Patient Name **Signature** **Date**

PERSONAL REPRESENTATIVE, FAMILY OR OTHER AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION TO BE USED AND / OR DISCLOSED.
Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

____ ________________________ __________________________
Name of Authorized Person or Entity Relationship Phone #

____ ________________________ __________________________
Name of Authorized Person or Entity Relationship Phone #

AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/ OR VOICE MAIL.
Rockville Gynecology and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our office leave messages on communication devices provide by our patients. Due to the new federal mandated HIPAA Privacy Rule we must obtain your authorization to continue this mode of communication. Protected Healthcare information that we may possibly disclose on your home, work or cell phone would include, but is not limited to: prescription/pharmacy information, test/lab results, appointment instructions for visits and procedures, and surgical posting/scheduling information.

_______ (Initial) **Yes, I agree** to allow Rockville Gynecology/ healthcare staff to leave messages that include Protected Healthcare Information on the following: please initial next to the applicable communication devices: _____ home number, ______ work Number, ______ cell number.

_______(Initial) **No, I do not** agree to allow Rockville Gynecology/ healthcare staff to leave messages that include Protected Healthcare Information on my home, work or cell phone numbers.

____ ____ _____________
Print Patient Name **Signature** **Date**

Would you like to be tested for HIV today? Yes or NO

********UNABLE TO OBTAIN NOTICE RECEIPT ACKNOWLEDGMENT*********
I attempted to obtain a signed Notice Receipt Acknowledgement from the patient on ___/___/___, but was unable for the following reasons:
____
Print Patient Name: ____ Account #: ____________________
I, ____ attest that the above statements are true and correct.
Employee Signature: ____ Date: ___________________