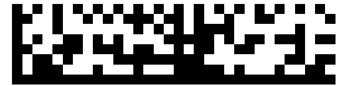
NEW PATIENT REGISTRATION FORMS

TEST, A 01/02/99 #25



* 814296w7775 A-HIPAA

PRIVACY POLICY

I understand that this office will not disclose my private health information (PHI) to anyone except as stated in this form or as required by law or upon my written authorization only. I authorize this clinic staff to discuss my PHI with the following: (Specify full name, relationship, Phone number)

What information may we release?

_____All PHI (Personal Health Information)
_____Billing information
_____Office notes
_____Psychotherapy/mental health
_____Lab/ Diagnostic test results
_____Prescription
_____Appointment information
_____Other ___________________________________

I authorize this office to release my insurance information and protected private health information (PHI) that is required to process medical claims and to perform treatment, payment and healthcare operations (TPHO).
I understand that it is my responsibility to inform this office of name, address, fax number of my provider/s, if I want my records faxed.
I authorize release of my records to and coordination of my care with the following HOME HEALTH agency, if applicable

I authorize my provider's office and its authorized affiliates to contact me to remind me of my appointments and balance due by: (please provide # or email)

Telephone Text/SMS #

EMAIL

I consent to receive automated phone calls from our practice. **(Please circle one) Agree or Disagree**

I authorize this office to get my medication history from pharmacy, insurance, other providers to assist provider in delivering my health care.
I understand that I may request individuals to leave the exam room at any time.
I acknowledge that I have received or been given the opportunity to receive a copy of the HIPAA Privacy Policies and understand that if I have any questions or complaints, I should contact the Administrator.

PHOTO DOCUMENTATION
I hereby grant authorization for the clerical staff to make a copy of my photo identification to be included in my confidential record as well as take a digital picture for additional protection against the theft of my medical identity. I further grant authorization for the clinical staff to take photo documentation of any injury or procedure that they feel is medically necessary to include in my confidential medical record.

Signature **Date**