HIPAA Information and Consent Form

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review carefully. The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. These safeguards include restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you or your family with treatment. HIPAA provides certain rights and protections to you as the patient. We must balance these needs with our goal of providing you with quality service and care. This form is a "friendly" version. A more complete text is available per your request and additional information is available from the U.S. Department of Health and Human services at www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, hospitals, as is necessary and appropriate for you care. We specifically use electronic charts as our method of medical records. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents and information.

2. It is the policy of the office to remind some patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the confidentiality rules of HIPAA.

4. The patient understands and agrees to inspections of the office and the review of documents which may include PHI by government agencies or insurance companies in the normal performance of their duties.

5. The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or office manager.

6. Your confidential information will not be used for purposes of advertising or marketing of products, goods, or services. Such prohibition does not include treatment/product samples or goods of normal value.

7. The practice agrees to provide the patient with access to their records in accordance with the state laws.

8. The practice may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request changes in certain policies used within the office concerning your PHI. However, the practice is under no obligation to alter internal policies to conform with your request.

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent and acknowledgement shall remain in force indefinitely.

_____ _____

Signature Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(HIPAA AUTHORIZATION)

A. Statement of Intent

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act of 1996 (HIPAA), that there are federal regulations that interpret and implement that law, and that HIPAA limits disclosure of my "Individually Identifiable Health Information" to certain of my family and friends, regardless of my state of health. I am signing this authorization so my health care providers can disclose my health care information to the person(s) listed below, and openly discuss that information with them.

B. Authorization

I, _____, hereby authorize my physicians, nurses, hospitals, and other health care providers to fully disclose my Individually Identifiable Health Information to any or all of the following authorized person(s):

Name:_____

Address: _____

Phone: _____

_____

(Signature)