Patient Name:_____

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.

What does HIPAA involve: Specifically, there are rules and 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 with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. 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 services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. Providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for handling of charts, patient records, PHI and other documents or information.

2. We may place a courtesy call or send a courtesy text or e-mail to the phone number or e-mail address you listed in your file in regards to your appointment. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

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

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We 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 PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidental communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I request the following restrictions to the use or disclosure of my health information:_____

_____

Do we have your permission to:

- Send appointment reminder cards to your home? ___Yes ___ No
- Can we call you at home? ___ Yes ___ No Leave a message at your home? ___ Yes ___ No
- Can we call you at work? ___ Yes ___ No Leave a message at your work? ___ Yes ___ No
- Can we call you on your cell phone? ___ Yes ___ No Can we contact you via e-mail? ___ Yes ___ No
- Other:_____

What is your preferred method of contact: Home (call) or Cell (text) or Other? _____

Whom may we discuss treatment, payment and appointment information with? (ex.: spouse, children, relatives, friends, caregiver)

Name:_____

I do hereby consent and acknowledge my agreement set forth in the HIPAA Information Form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature _____ **Date:** _____