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HIPAA Information Consent From

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: 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 offices 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. 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 the 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.
2. 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.
3. You understand and agree to inspections of the office and review of documents which may include PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
5. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
6. We agree to provide patients with access to their records in accordance with state and federal laws.
7. We may change, add, delete, or modify any of these provisions to better serve the needs of both the patient and the practice.
8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used with in the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Please list the following people we are allowed to give information regarding your care:

Name:________________________________ Relationship:______________________

Name:________________________________ Relationship:______________________

Name:________________________________ Relationship:______________________

Please check the following that apply:

1. Call or leave message on answering machine at home? Yes or No
2. Call or leave message at work? Yes or No

Acknowledgement Form:

Patient Name:________________________________ Birth Date:__________________

If patient is under the age of 18, person that is responsible will sign below. Otherwise, patient will sign.

I, _________________________ date ____________ do here by 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 shall remain from this time forward, with no expiration date.