



## 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. Many of the policies have been *our* practice for years. This form is a “friendly” version. By signing this form you acknowledge that you have received a copy of our Notice of Privacy Practices to read.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified on 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. Dept. of Health and Human Services. [www.hhs.gov](http://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 of information which is not already a matter of public record. The normal course providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination rooms, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
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 by government agencies or insurance payers in normal performance of their duties.
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 practice and the patient.

If you would like information to be obtained by family members, friends, etc...please list those below. **If you do not have anyone listed below they will not be able to call into our office for information regarding your care including your appointment date or time.**

I authorize release of information to the following:

NAME \_\_\_\_\_

NAME \_\_\_\_\_

NAME \_\_\_\_\_

NAME \_\_\_\_\_

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 shall remain in force from this time forward.

SIGNATURE OF PATIENT \_\_\_\_\_ DATE \_\_\_\_\_