

PATIENT CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help ensure that personal health information (PHI) is protected for privacy. The “Privacy Rule” was also created to provide a standard of certain health care providers to obtain their patient’s consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, you should know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and we may have to disclose PHI for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your PHI, but this must be in writing.

Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your PHI. If you choose to give consent in this document, you may request to refuse all or part of your PHI at some further time. You may not revoke actions that have already been taken that relied on this or a previously signed consent.

You have the right to review our privacy notice, request restrictions and revoke consent in writing after you have reviewed our privacy policy.

If you have any objections to this form, please ask to speak with our HIPAA compliance officer.

Print Name _____ Signature _____ Date _____

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Would you like to give us permission to release information to any particular family member or friend if necessary?

Yes No If yes, to whom? _____

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COMPLIANCE ASSURANCE NOTIFICATION

The misuse of personal health information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA), with particular emphasis on the “Privacy Rule.” We strive to achieve the very highest standards of ethics and integrity in performing services for the patients.

It is our policy to properly determine the appropriate use of PHI in accordance with the government rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a compliance program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and patients without any thought of penalization if they feel that an event in any way compromises the integrity of the policy. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly-valued patients.