



## Patient HIPAA Acknowledgement and Consent Form

Patient Last Name	Patient First Name	MI	Date of Birth (MM/DD/YYYY)

**Disclosures to Friends and/or Family Members\***

**DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM *THE CLINIC* AND ITS BUSINESS ASSOCIATES MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?**

I give permission for my Protected Health Information (PHI) to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1.			
2.			
3.			
4.			
5.			

\*Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

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## Notice of Privacy Practices

\_\_\_\_\_ (**Patient/Representative initials**) I acknowledge that I have received *The Clinic's* Notice of Privacy Practices, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by *The Clinic* (the Provider/Clinic) and/ or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practices.

## Communication about My Healthcare

\_\_\_\_\_ (**Initials**) I agree *The Clinic* (Provider) or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

## **Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:**

\_\_\_\_\_ (**Initials**) **If at any time I provide an email address or cellphone number** at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but are not limited to: post-procedure instructions, follow-up instructions, educational information, and medication information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for my care. You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

**Note:** This clinic uses an Electronic Health Record that will update **all your demographics and consents** to the information that you provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

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## Consent for Photographing or Other Recording for Security and/or Health Care Operations

\_\_\_\_\_ (Initials) I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

## Release of Information

\_\_\_\_\_ (Initials) I hereby permit *The Clinic* (practice/clinic) and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility (*The Clinic*) may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

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I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

<b>Patient/Representative Signature</b>	<b>Relationship to Patient</b> (self, legal guardian/representative, etc.)	<b>Date</b>