Privacy Consent Form as Required by Federal HIPAA Law #101-191

❖ Trust is the foundation of the doctor/patient relationship.
❖ The information that you provide us is kept in the strictest of confidence.
❖ While protecting your privacy is extremely important to us, there may be certain situations in which we may have to use or disclose your private health information.
    1. It may be necessary to use or disclose your private health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your condition.
    2. It may be necessary to use or disclose your private health information and billing records to another party if they are responsible for the payment for your services.
    3. It may be necessary to use or disclose your private health information within our practice for quality control and operational purposes.
    4. Furthermore, you should know that your records are subject to all legitimated processes of law (e.g. subpoena).

Patient Rights Under HIPAA Law #101-191
    1. You have the right to request that we do not disclose your private health information to specific individuals, companies or organizations under the following circumstances:
        a) All requests must be in writing.
        b) By law we are not required to agree with your restrictions HOWEVER:
        c) If we agree with your restrictions, the restrictions are binding on us.
    2. You have the right to REVOKE your Authorization under certain conditions:
        a) It must be writing.
        b) The request will not be honored if we have already released your private health information before we receive your request to revoke the authorization.
        c) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your private health information should they decide to contest any of your claims.
❖ I have read this consent policy and agree to its terms.
❖ I acknowledge that I have received a copy of this form for my own records.

_____
Printed Patient Name

_____   _____
Signature of Patient   Date