HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Many policies have been our practice for years. This form is a condensed version, and the full version is available in the office if you would like to see a copy at any time.

The basics: 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 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 service and care.

We have adopted the following policies;

1. Patient information will be kept confidential except as necessary to provide services and to ensure that all administrative matters related to your care are handled appropriately. This includes sharing information with other healthcare providers, laboratories, and insurance carriers. Your patient chart and any of its contents will only be available to our office team for these purposes. You agree to the normal procedures and use of your information in this capacity.
2. It is the policy of the office to remind patients of their appointments. We may do this by telephone, e-mail, text, or U.S. Mail. We may send you other communications informing you of changes in office policy, upcoming events, or any other informative information. If these come to you electronically you will always have the option to opt out.
3. The practice utilizes a number of vendors in the conduct of business. These vendors will comply with the confidentiality rules of HIPAA if any patient information is encountered.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance companies in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and our patients.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____(print name) 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 this consent shall remain in force from this time forward unless I revoke consent.

Patient Signature _____ Date_____