

HIPAA CONSENT FORM

The Health Portability and Accountability Act of 1996 provide safeguards to protect your privacy. These Safeguards include 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 or your family with treatment. HIPAA provides certain rights and protections to you as the patient. We must balance these needs with our goal to providing you with quality service and care. For this reason, our practice has adopted the following polices:

1. Patient information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care and handled appropriately. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of the office to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the rules of confidentiality.
4. The patient understands and agrees to inspections of the office and review of documents which may include PHI by government agencies or insurance companies through the normal performance of their duties.
5. The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or office manager.
6. Your confidential information will not be used for purposes of advertising or marketing of products, goods, or services. Such prohibition does not include treatment / product samples or goods of normal value.
7. The practice agrees to provide the patient with access to their records in accordance with state law.
8. The practice may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

I, _____ (Patient or Guardian), do hereby agree to the terms set forth above and any subsequent changes in the office policy. I understand that this consent shall remain in force so long as I am a patient of this practice.

Patient or Guardian Signature: _____ Date: _____