HIPPA ACT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (**HIPAA**), I have certain rights to privacy regarding my **protected health information**, I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your NOTICE OF PRIVACY PRACTICES containing a more complete description of the users and disclosures of my health information. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time, and that I may cause this organization at any time at the address below to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this acknowledgement in writing at any time, except to the extent that you have acted relying on this acknowledgement.

DESIGNATED FAMILY MEMBER AUTHORIZATION

In the event that a family member is required to discuss m medical condition, I assign the following authorized representative to be the primary source of communication regarding my medical condition.

ANSWER PHONE AUTHORIZATION

I have given the above entity my permission to leave non-emergency messages or normal tests results on my answer phone. I understand that this authorization will remain in effect until I revoked in writing by me.

EMAIL AND MAIL AUTHORIZATION

I give the above entity my permission to email and mail non-emergency messages and/or test results to my designated email address and home address. I understand that communication by email can be non-confidential, and this authorization will remain in effect until revoked in writing by me.

I hereby acknowledge that I do have an option of obtaining a copy of this Notice of Privacy Practices containing detailed description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this practice has the right to change its Notice of Privacy Practices from time to time that I may contact this practice any time to obtain a current copy of the Notice of Privacy Practices.

Patient Name: _____ (IF) Authorized representative _____
Signature: (patient)_____ (if authorized representative) _____
EMAIL: _____
Date: _____

MEMBER ELIGIBILITY WAIVER FOR HMO, PPO PATIENTS: In case verification of your coverage for health plan benefits cannot be made at this time, Services will be provided to you at this visit. In the event your coverage is not effective, you will be held responsible for payment.

Signature _____