



Patient HIPAA Acknowledgement and Consent Form

Patient Name (Printed) _____

MI Date of Birth (MM/DD/YYYY) _____

Notice of Privacy Practices.

_____ (Patient/Representative initials) I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, 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 Provider 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 Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information 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.

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

Communication about My Healthcare

I agree the 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:

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 not be limited to follow-up instructions, educational information, and prescription 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 medical care. Note: You may opt out of these communications at any time. The practice 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 just provided.

Release of Information.

I hereby permit 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 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. 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 may be a member of one or more such organizations. This consent specially 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.

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

Patient/Representative Signature _____

Relationship to Patient (self, parent, legal guardian/representative, etc.) _____

Date _____

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. For us to release a prescription to your family



member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

_____ I do want (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

Name Relationship

_____ I do not want (Patient/Representative Initials) to designate anyone to pick up my prescription order.