## HIPAA Consent Document

**Service Date:**
Patient:

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**Acknowledgment of receipt of notice of privacy practice and consent to treat**: By my signature below, I hereby acknowledge that I have received a copy of the Clinic's NOTICE OF PRIVACY PRACTICES (attached below).
**Consent to treatment**: By my signature below, I do hereby voluntarily consent to treatment by the provider(s) of the clinic for an examination and to any related diagnostic procedures and treatments as necessary in the judgment of the provider(s). I acknowledge that the practice of medicine is not an exact science. I acknowledge that no guarantees have been or can be made to me as a result of such procedures and treatments.
**Consent to disclose my general health information**: By my signature below, I hereby authorize the clinic to disclose my medical information so that the clinic may treat me, seek payment from third parties for such treatment, and generally carry on the health care operations of the clinic (e.g., quality assurance). I also authorize the clinic to disclose my medical information to insurers and providers outside of the clinic when necessary for purposes of my treatment, payment for that treatment, and for their health care operations. By my signature below, I also authorize the clinic to communicate with me by phone (using the numbers listed above) and to disclose my general health information on my home answering machine/voicemail, on my cell phone voicemail, and to my spouse, children, and the following additional family and friends.

**Additional friends/family (names)**:

**Acknowledgment of financial responsibility** : By my signature below, I understand that it is my responsibility to supply the clinic with current insurance information and/or any referral authorization forms that may be necessary for my insurance. I am aware that if I have a routine diagnosis my insurance may not cover the examination. I understand that insurance companies require beneficiaries to pay deductibles, company insurance, co-payments, and any non-covered services at the time services are rendered. I am aware that I am responsible for any unpaid balances. I authorize the clinic to charge my credit card on file or send an invoice for any outstanding balance. If my account results in collection agency involvement, the undersigned, guarantor receive all payments for services rendered to me or my dependents. By my signature below, I agree to all of the above while I am a patient of the Clinic.

**Signature of Patient**:

**Your Information. Your Rights. Our Responsibilities**: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
**You have the right to**: Get a copy of your paper or electronic medical record.Correct your paper or electronic medical record.Request confidential communication.Ask us to limit the information we share.Get a list of those with whom we've shared your information.Get a copy of this privacy notice.Choose someone to act for you.File a complaint if you believe your privacy rights have been violated.
**Your Rights**: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.
**Get an electronic or paper copy of your medical record**: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct your medical record**: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.We may say "no" to your request, but we'll tell you why in writing within 60 days.
**Request confidential communications**: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.We will say “yes” to all reasonable requests.
**Ask us to limit what we use or share**: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
**Get a list of those with whom we’ve shared information**: You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
**Get a copy of this privacy notice**: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
**Choose someone to act for you**: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.We will make sure the person has this authority and can act for you before we take any action.
**File a complaint if you feel your rights are violated**: You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.
**Your Choices**: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
**In these cases, you have both the right and choice to tell us to**: Share information with your family, close friends, or others involved in your care.Share information in a disaster relief situation.Include your information in a hospital directory.
**If you are not able to tell us your preference**: for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
**In these cases we never share your information unless you give us written permission**: Sale of your information.Most sharing of psychotherapy notes.
**In the case of fundraising**: We may contact you for fundraising efforts, but you can tell us not to contact you again.
**How do we typically use or share your health information?**: We typically use or share your health information in the following ways.
**Treat you**: We can use your health information and share it with other professionals who are treating you.
**Example**: A doctor treating you for an injury asks another doctor about your overall health condition.
**Run our organization**: We can use and share your health information to run our practice, improve your care, and contact you when necessary.
**Example**: We use health information about you to manage your treatment and services.
**Bill for your services**: We can use and share your health information to bill and get payment from health plans or other entities.
**Example**: We give information about you to your health insurance plan so it will pay for your services.
**How else can we use or share your health information?**: We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
**We can share health information about you for certain situations such as**: Preventing diseaseHelping with product recallsReporting adverse reactions to medicationsReporting suspected abuse, neglect, or domestic

violence. Preventing or reducing a serious threat to anyone’s health or safety
**Do research**: We can use or share your information for health research.
**Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
**Respond to organ and tissue donation requests**: We can share health information about you with organ procurement organizations.
**Work with a medical examiner or funeral director**: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
**We can use or share health information about you:**: For workers' compensation claimsFor law enforcement purposes or with a law enforcement official. With health oversight agencies for activities authorized by lawFor special government functions such as military, national security, and presidential protective services
**Respond to lawsuits and legal actions**: We can share health information about you in response to a court or administrative order, or in response to a subpoena.
**Device Technology**: We can share health information about you when we use our technology input devices for voice file transcription technologies and screen reading technologies on our smart phones, tablets and computers to document care and practice management.
**Social Media and Community Success**: We can share health information about you that you share with us including testimonials and pictures regarding your care and interactions with our clinic.
**Our Responsibilities**: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.We must follow the duties and privacy practices described in this notice and give you a copy of it.We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
**For more information see**: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html
**Changes to the Terms of this Notice**: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.