SOUTHERN INDIANA Community Health Care

PAOLI · MARENGO · WEST BADEN · ENGLISH · SALEM · BEDFORD · MITCHELL

HIPAA COMPLIANCE PATIENT CONSENT FORM

PATIENT NAME: **DATE OF BIRTH:**

Our notice of privacy practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your right under the law. You ascertain that by your signature that you have reviewed our notice before signing this. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with the restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to this consent in writing, signed by you the patient. However, such a revocation will not be retroactive. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by the law.
- The patient has the right to restrict the use of the information by the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. This authorization will be effect until such time or if patient is a minor until he/she turns 18 years of age.
- The practice may condition receipt of treatment upon execution of this consent.
- It may not be possible to ensure you right to the protection of the privacy of this information once Southern Indiana Community Health Care, Inc. discloses it to another party.
- Received a copy of the UPDATED on 1/10/18 Notice of the Privacy Practices or have been offered a copy of the updated Notice of the Privacy Practices but declined to accept a copy.
- Been Notified Out of Network Provider Referral Law Change in our Notice of the Privacy Practices.

May we contact you to confirm your appointment? ☐ Text ☐ Phone ☐ Do Not Contact

May we leave a message? ☐ Yes ☐ No

Authorization to discuss your information with family, friends, or caregivers

***** I prefer not to have my medical condition discussed with anyone other than myself _____ *****

To comply with the new HIPAA federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else including your family, friends, and caregivers. By authorizing this we will be able to, without your presence, discuss your case, answer questions leave detailed messages and contact in the event of an emergency, to the person(s) listed below. This authorization is optional and can be withdrawn at any time by you in writing.

PLEASE LIST ANYONE THAT CAN GET INFORMATION INCLUDING PARENTS/GUARDIAN

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

Emergency Contact & Relationship: _____ Phone: _____

Acknowledgement of Receipt of Privacy Notice

_____I acknowledge that I have (1) received a copy of the Updated Notice of the Privacy Practices or (2) have been offered a copy of the Notice of the Privacy Practices but declined to accept a copy.

_____

Patient/Guardian Signature **Relationship to Patient (if other than self)** **Date Signed**