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Patient Name:	**Date of birth:**

Southern Indiana Community Health Care, Inc.
HIPAA compliance Patient Consent Form

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. 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, including participation with a regional health information exchange hub used to optimize your medical care in multiple settings or the potential anonymous usage in a public health format such as a grant or publication.
- 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. A covered entity is not required to agree with the requested restrictions but is bound by any restrictions to which it agrees. *See* 45 CFR 164.522(a).
- 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 in effect for 3 years from date of signature or if the patient is a minor until he/she turns 18 years of age.**
- It may not be possible to ensure your right to the protection of the privacy of this information once Southern Indiana Community Health Care, Inc. discloses it to another party.
- I received a copy of 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.
- I have been notified of the Out of Network Provider Referral Law Change in our Notice of Privacy Practices.

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

To comply with the new HIPAA federal Privacy Regulations, we must receive your written approval to discuss your case with others, 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, 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:**

I hereby acknowledge that I can receive a copy of the Medical Practice's Notice of Privacy Practices upon request.
Initial: _____

The following Patient has read this HIPAA Consent and, by signing below, acknowledges its receipt and agrees to consent to our use and disclosure of your Protected Health Information as outlined in the Notice of Privacy Practices.

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