GulfView Medical Institute PL
A new approach to health.

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing signed by you, at any time. However, such revocation shall not affect any disclosures that we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health careoperations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review thisNotice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information but the Practice does not have to agreeto those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR PROTECTED HEALTH INFORMATION (This includes step-parents, grandparents, and any other care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT, AND BILLING INFORMATION VIA:**

- ☐ Cell phone confirmation
- ☐ Home phone confirmation
- ☐ Work phone confirmation
- ☐ Text message to my cell phone
- ☐ Email confirmation
- ☐ Any of the Above

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE COVERED VIA:

- ☐ Cell phone confirmation
- ☐ Home phone confirmation
- ☐ Work phone confirmation
- ☐ Text message to my cell phone
- ☐ Email confirmation
- ☐ Any of the Above

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFORMATION** ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

- ☐ Text message
- ☐ Email
- ☐ Any of the above
- ☐ None of the above (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with knowledge and consent.

This Consent was signed by: _____

Printed Name – Patient or Representative

_____ ____/____/____

Signature Date

_____

Relationship to Patient (if other than patient)

Witness: _____

Name

_____ ____/____/____

Signature Date

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____

I could not communicate with the patient _____

The patient refused to sign _____

The patient was unable to sign _____

Other (please describe) _____