HIPAA PRIVACY ACT PATIENT CONSENT FORM

_____ _____ _____

Print Patient Name **Date of Birth** **Account #**

The Health Insurance Portability and Protection Act (HIPAA) requires all medical providers, insurance companies, and other entities to implement controls to ensure the safety and security of personal health information.

By signing this form, you consent to our use and disclosure of protected health information about you, your treatment, payment, and health care operations/procedures. You have the right to revoke this consent IN WRITING; except where we have already made disclosures based on your prior signed consent or as required by law. If you choose to decline, **PLEASE PROVIDE A WRITTEN DECLINE** so that we may have a copy.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you as a patient. You have the right to review our notice before you sign this consent. Copies are available upon request at the front desk.

_____ _____ _____

Responsible Party (Please Print) Signature of Responsible Party Date

<u>Authorization to Release Information</u>

I authorize the release of medical records to/from another physician said assignee; Who is consulting on my care to ***Shenandoah Head and Neck Specialist, PLLC and SHNS Hearing Services, LLC*** to assist in the continuity of my care.

I authorize this office to speak with the individuals listed below regarding my appointment times, rescheduling of my appointment, insurance/billing inquiries, test results, and medical conditions/care. If there is an additional person you would like to add the release of information to; Please provide your VERBAL CONSENT with our associates to keep on file until the HIPAA privacy form is updated.

1. Name: _____ Relationship to Patient: _____

   Phone Number of Above: (_____) _____ - _____

2 Name: _____ Relationship to Patient: _____

   Phone Number of Above: (_____) _____ - _____

I hereby authorize my listed emergency contact to be included in the above: Initial: _____

Please call: (_____) _____ - _____ Home Cell Work

If unable to reach me (PLEASE CHECK THE PREFERRED OPTION)

( ) It is acceptable to leave a detailed message, this may include test results, appointment/insurance information, medical concerns and/or plan of care information
( ) Please leave a message asking me to return your call

You have the right to revoke this consent at any time, except where disclosure has already been made by your prior signed consent. I permit a copy of this authorization to be used in place of the original copy provided.

_____ _____ _____

Responsible Party (Please Print) Signature of Responsible Party Date