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Capital OB/GYN

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RELEASE OF INFORMATION AUTHORIZATION

In accordance with new Health Information Privacy laws, we are no longer allowed to release information to family members, leave information on voicemail systems, or take treatment requests from family members without your written consent. **Please complete the following information**.

1. Please list all individuals who are authorized to receive your health information.

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

2. Please list all individuals who may request treatments for you or may call with medical complaints (i.e., medication refills, referrals, treatment for illnesses).

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

3. Are we allowed to leave information on your home answering machine? ☐ YES ☐ NO

4. Are we allowed to leave information on your work voicemail system? ☐ YES ☐ NO

5. Is there an email address you would like us to use instead? ☐ YES ☐ NO

IF YES, _____

6. Are there any specific topics of information that you would like us NOT to release to anyone other than you? ☐ YES ☐ NO

IF YES, PLEASE LIST THESE TOPICS _____

_____

_____

PATIENT NAME : _____

Please print

➘ **SIGNATURE** _____ **DATE** _____

MM/DD/YYYY

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PATIENT CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION (PHI)

As stated in the Patient Consent Form, the Department of Health and Human Services has established the Health Insurance Portability and Accountability Act (HIPAA) in order to safeguard your Personal Health Information (PHI). PHI is defined as your name, date of birth, social security number, address, phone number, insurance information, as well as your medical history.

There are times when it is necessary for us to release this information to carry out treatment, payment, and daily healthcare business operations. By signing this Patient Consent for Disclosure of PHI, you are acknowledging that it may be necessary to release information to your insurance company, pharmacist, or other healthcare organization.

It is also necessary to acknowledge that there may be times that your PHI is inadvertently disclosed or is audible to other non-healthcare personnel. Some of these situations are listed below:

1. Your name and date of birth may be audible to other patients throughout the day while we are providing treatment or completing standard healthcare business operations.
2. Your PHI may be released to the courts via subpoena.
3. Your PHI may leave the office premises during certain times.
4. Your PHI may be disclosed during health insurance site audits of our policies and procedures.
5. Your name and phone number may be visible on our sign-in log.

The above listing is to highlight examples and is not meant to be all-inclusive.

Please note that in accordance with the Privacy Rule, we require a written release to provide any medical information to a family member.

By signing below, I acknowledge and accept that my Personal Health Information may be released to other medical institutions and may be inadvertently disclosed to other non-healthcare personnel.

PATIENT NAME : _____

Please print

➘ **SIGNATURE** _____ **DATE** _____

MM/DD/YYYY

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PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that Personal Health Information (PHI) is protected for privacy. The Privacy Rule was also created to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of PHI about the patients in order to carry out treatment, payment, or healthcare operations.

As our patient, we want you to know that we respect the privacy of your PHI and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we believe are in need of your healthcare information and information about treatment, payment, or healthcare operations, in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not with patients), and may have to disclose your PHI for purposes of treatment, payment, or healthcare operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your PHI, but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your PHI. If you choose to give consent in this Patient Consent Form, at some future time, you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken and that relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

PATIENT NAME : _____

Please print

➘ **SIGNATURE** _____ **DATE** _____

MM/DD/YYYY

✂

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our Valued Patients:

The misuse of PHI has been identified as a national problem, causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA), with particular emphasis on the Privacy Rule. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients, without any thought of penalization, if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.