HIPAA Compliance Form

If you feel that you privacy protections have been violated, you have the right to file a written complaint with our office, or with the department of Health & Human Services, Office of civil rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. For more information about HIPAA or to file a complaint contact:

The U.S. Dept. of Health & Human Services
Of Civil Rights
200 Independence Ave. SW
Washington, D.C. 20201
(202) 619-0257 or 1 (877) 696-8775

Authorization to Release Medical Information

Do not release my medical information to anyone except as detailed in the HIPAA notice of Privacy Practices

Or,

I give permission to disclose medical information to the following. For example: John Doe, father, (000) 000-0000

Recipient _____ Relationship _____ Contact phone # _____

Recipient _____ Relationship _____ Contact phone # _____

Recipient _____ Relationship _____ Contact phone # _____

Recipient _____ Relationship _____ Contact phone # _____

Patient Rights and Responsibilities

Rights:

To receive service in a reasonable period
To receive medically necessary service
To be treated with respect and courtesy
To receive available information regarding visit
To have your medical coverage explained
To participate in treatment decisions
To receive a second opinion regarding treatment
To review or to receive a copy of your medical record subject to legal restrictions and reasonable copying charges
To request review of your medical record by the Physician, and to request corrections if necessary
To be given information on how to file a complaint/ Grievance
To formulate and advance directive if you have a life threatening illness or injury

Responsibilities:

Having appropriate ID, Insurance Cards. Coverage stickers at appoint.
Keeping appointments or contacting this office to cancel appointment
Fulfilling financial obligations at the time of service e.g. Copay,
providing complete and accurate information
following the health plan you and your physician agree on
being considerate to others
providing legal documents of guardianship for minor being treated
providing a list of persons who may receive medical information about you, on your behalf, in case of emergency.

I have read and understand the HIPAA Notice of Privacy Practices and Patient Rights and Responsibilities as stated above. These policies may change from time to time. I may request a current copy of this form at any time. I also agree to release (or not release) information as per the Authorization to Release Information Section.

Patient Name: _____ Patient Date of Birth: _____

Signature: _____ Date: _____

Signatory's Relationship to patient: _____