HIPAA Authorization Form

Family Health Service (FHS) has taken measures to protect all of our patients' private medical information. FHS will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices. Your protected health information will be used by FHS or disclosed to others for the purpose of the treatment, obtaining payment, or supporting the day-to-day health care operations of the practice. You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be sued or disclosed. You may review the notice prior to signing this consent. You may also request a copy of the Notice of Privacy Practices for your own records. See the receptionist to receive a copy. You may request a restriction on the used or disclosure of your protected health information. FHS may or may not agree to restrict the use or disclosure of your protected health information. If FHS agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards. You may revoke this consent to the use and disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. PCHC reserves the right to modify the Privacy Practices outlined in the notice.

Please see the receptionist with any questions prior to signing this authorization form.

I, _____, DOB _____ am authorizing the person/people listed below to obtain medical information about myself. I understand FHS is not responsible for the information provided as long as it is given to a person that I have listed below. Date of Birth must be provided so that our office can verify that we are speaking to the correct person.

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

I have reviewed this consent form & give my permission to FHS to Use & Disclose my health information in accordance of the Federal Privacy Standards.

Patients Signature: _____ Date: _____

If guardian, relationship to patient: _____

Over

I, _____, do not authorize FHS to release any of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

Patient's Signature: _____ Date: _____

If guardian, relationship to patient: _____

I, _____, do authorize this emergency contact

_____ to be called only in case of emergency. I understand none of my private information will be released.

Relationship:_____ Phone:_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

May Family Health Services (FHS) leave a message on your answering machine or voicemail regarding the following: Scheduled appointments, premedication and instruction appointments
YES NO

Assignment of Insurance Benefits, Release of Information and Authorization of Treatment. I, the undersigned authorize my insurance benefits to be paid directly to the provider of Family Health Services for services rendered. I understand that I am ultimately financially responsible for any balance due for approved and covered charges not paid by insurance. I hereby authorize Promise FHS to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance claim submissions. I understand that payment is expected at the time services are rendered. A copy of this is as valid as the original.

Signature: _____

Date: _____