

HIPAA INFORMATION AND CONSENT FORM

Center for Family Healing

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. A more complete text is available upon request.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This includes the sharing of information with other healthcare providers, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in secured filing cabinets or by password if stored electronically. The normal course of providing care means that such records may be left, at least temporarily in administrative areas such as the front office. Those records will not be available to person other than office staff. You agree to the normal procedures utilized with the office for the handling of charts, patient records, PHI and other documents of information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, or text. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. This practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which include PHI by insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complains regarding privacy to the attention of the office manager.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods and services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and patient.
9. You have the right to request restrictions in the uses of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to conform to your request.

I, _____, date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA information form and subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.