HIPAA Consent Form

I understand that as part of my healthcare, Rocky Run Family Medicine originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that the services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have access to a HIPAA Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand I have the right to review the notice prior to signing this consent. I understand the practice reserves the right to change their notice and practices and a need to use or disclose my Protected Health Information (PHI). I also understand that I have the right to restrict how my PHI may be used or disclosed to carry out treatment, payment, or healthcare operations and that the practice is required to agree to the restrictions requested. I understand that I may revoke this consent in writing. Any patient, guardian, or personal representative has the right to request to receive confidential communication of PHI by alternative means or alternative locations. Such requests must be in writing and the practice must accommodate reasonable requests.

With this consent, Rocky Run Family Medicine may mail to my home or other designated location any appointment reminders and other correspondence marked personal and confidential that assist the practice in carrying out treatment, payment, and healthcare operations.

By signing this form, I am giving my consent to Rocky Run Family Medicine to use and disclose my PHI to carry out treatment, payment, and healthcare operations.

I may revoke my consent in writing.

Patient Name:_____ DOB:_____

Signature:_____ Date:_____