HIPAA Consent Form

I understand that as part of my healthcare, the physicians of Adriatica Women's Health (AWH) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

AWH's *Notice of Privacy Practices* provides specific information and complete description of how my private health information (PHI) may be used and disclosed. I have been provided a copy of our access to the *Notice of Privacy Practices* and understand that I have the right to review the notice prior to signing this consent. I understand that AWH reserves the right to change the *Notice of Privacy Practices.* I understand that I have the right to restrict the use and/or disclosure of my PHI for treatment, payment or healthcare operations and that AWH is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that AWH has already taken action in reliance of my prior consent. This consent is valid until revoked by me in writing.

We may change our policies and this notice at any time and have those revised policies applied to all the PHI we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact Donna Bourne, 972-542-8884.

NOTE: AWH must obtain your written authorization to use your PHI for any purpose other than treatment or billing. If you want AWH to have access to disclose your PHI to your spouse of any other person during your treatment, please list and sign below.

I agree to allow AWH to disclose my PHI (including date/time of appointments) to:

___ My Spouse____ (printed name and phone number)

___ Other Member(s) of my Family____

___ Other____ (printed name and phone number)

___ Myself only, no other family member (Does not apply to minors)

This does not serve as an Authorization to Release Medical Record

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed AWH's *Notice of Privacy Practices* 2017.

____ _________________________________

Signature of Patient or Legal Representative Date

____

Print Name of Patient or Legal Representative

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)_______________________

Witness: ____ **Date:** ___________________________