Intracoastal Internal Medicine – HIPAA ACKNOWLEDGEMENT & CONSENT

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

***Can we leave your medical information on your voice mail? ☐ Yes ☐ No**

***Name of patient's pharmacy: ____**

****Name of patient's emergency contact: _________________________Relationship to patient:________________**

Emergency contact's phone number: _______________________

I acknowledge that a copy of the Patient Rights and Patient Responsibilities Policy and Privacy Policies Notice, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are available at www.intracoastalmedicine.com. A paper copy will be provided upon request.

Please be advised that without your *written authorization* we cannot discuss your case, treatment, or your pre – and post-procedure care instructions with *anyone* other than yourself. We need specific *written authorization* from you in order to be able to do so. Please indicate below with whom we may discuss your healthcare.

I hereby authorize Intracoastal Internal Medicine (IIM) to furnish all necessary information to appropriate parties such as insurance carriers, physicians, and attorneys concerning treatments rendered.

Please list any additional parties (e.g. spouse, children, significant other, or person responsible for providing care to you) to whom information, such as post-operative instructions, may be disclosed by IIM:

____

Name of Person(s) (Family member or Friend) and/or Organization

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If you would like to authorize someone other than yourself for IIM to speak with regarding your medical bills/financial responsibility, please provide authorization for us to speak to them regarding your account.

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Name of Person(s) (Family member or Friend) and/or Organization

Expiration date of authorization: This authorization is effective for one year from the date signed and will renew annually, unless updated by the patient.

Right to terminate or revoke authorization: You may revoke or terminate this authorization by submitting a written revocation to Intracoastal Internal Medicine. You should contact the Privacy/Compliance Officer to terminate this authorization.

Potential for re-disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under Federal Privacy Regulations.

Patient Name (please print): ____ Date of Birth: ________________

Patient Signature: ____ Date of Signature: ___________________

Signature of Patient Representative:_____________________________________ Relationship: ________________

Please Check all that may apply that you wish your designee(s) to have access to:

- **All my medical information**
- **Information necessary to schedule appointments for me**
- **Information necessary to help my family member(s) take care of me**
- **Information necessary to allow my family member(s) to pick up or arrange for medical equipment to be provided for me**
- **Information necessary to bill for or submit claims for care provided to me for government or private insurance payors and to make inquiries/payments regarding my account balance**