

**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

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

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

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.

Name of Person(s) (Family member or Friend) and/or Organization to discuss medical bills.

Patient's emergency contact: _____ Relationship: _____

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 health treatment or health questions with anyone other than yourself. We need specific written authorization from you in order to be able to do so. Please indicate above 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.

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: _____