HIPAA

ACKNOWLEDGEMENT

This is to certify that I, the undersigned hereby consent to and authorize the disclosure of any medical information to the following:

☐ HUSBAND ☐ WIFE ☐ CHILD ☐ PARENT

☐ OTHER, PLEASE SPECIFY: _____

May we leave a message at the contact number you provided? ☐ Yes ☐ No

May you be called at your place of employment to be informed of your medical information? ☐ Yes ☐ No

If you *do not want* a certain disclosure made to the above, it is *your responsibility* to *notify us.*

Thank you for your cooperation.

I HEREBY ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.

Witness:

_____
Witness Signature

_____
Date

Patient:

_____
Patient Signature

_____ _____
Print Name

Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policies, contact us at 412-461-8255

Patient's Consent

Name: _____

Address: _____

City: _____ **State:** _____ **Zipcode** _____

Telephone: _____ **E-Mail:** _____

Patient # : _____ **Social Security #:** _____

I, _____, have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes off healthcare operations treatment and payment activities.

Signature: _____ **Date:** _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____ Date: _____

Patient's Revocation

By signing below, you revoke your above consent for us to use and disclose your PHI. However by doing so , we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature: _____ Date: _____

If this consent revocation is signed by a personal representative on behalf of the patient complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____ Date: _____

This information is intended as advisory in nature and should not be considered as legal advice nor is it a substitue for legal action. This information does not constitute technical information system/security advice. It is designed to assist you in your own risk management activities. It is not intended to be exclusively relied upon or used as a substitute for your own loss control program. Accuracy and completeness are not guaranteed.