Sample Consent Form

Patient: _____
Practitioner: _____

In connection with the medical services that I am receiving from (Practice) and its medical staff, I hereby authorize (PRACTICE), the above-named practitioner, and their respective agents to disclose any and all information concerning my medical condition and treatment (including, but not limited to, super-confidential information concerning sexually transmitted diseases, mental health, chemical dependence, DNA samples or analyses, or other such information), including copies of applicable hospital and medical records to:

A. any third party payor covering the medical services of the patient;
B. other health care professionals and institutions involved in the delivery of health care to the patient;
C. The proponent of any legally sufficient subpoena, or in response to a court order;
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care operations, services and payment for such services;
E. Pharmacies; and
F. As otherwise required by law.

I further consent that photographs may be taken of me or parts of my body, under the following conditions:

1. The photographs may be taken only with the consent of my practitioner and under such conditions and at such times as may be approved by him.

2. The photographs shall be taken by my practitioner or by a photographer approved by my physician.

3. The photographs shall be used for medical records and, if, in the opinion of my practitioner, medical research, education or science will benefit from their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any purpose which he may deem proper in the interest of medical education, knowledge, or research. In such instances, however, it is specifically understood that in any such publication or use I shall not be identified by name and reasonable steps shall be taken to preserve my identity.

4. The aforementioned photographs may be modified or retouched in any way that my physician, in his discretion, may consider desirable.

When providing information to me, information may be transmitted to me by any or all of the following means (initial all that apply):

___ Telephone messages on an answering machine
___ Messages to the following family members or friends:

___ E-mail to the following address: _____

5. I also consent to the release of Protected Health Information to the following individual(s):

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given:

Special Restrictions:

_____

_____

This consent is valid from the date executed until revoked in writing by the patient.

Signed: _____
Date: _____
Witness: _____

Sample Privacy Notice

In accordance with the Health Insurance Portability and Accountability Act, patients of (Practice) are entitled to and afforded the rights to privacy regarding their health related information as set forth under applicable law. The Practice will strive to ensure that patient information is used only for purposes authorized by the patient and as otherwise required by law. Upon request we can provide you with a complete copy of our Privacy Policies.

Additionally, Patients have a right to review their medical records and furnish comments to their records during normal business hours, upon providing reasonable advance notice.

Moreover, patients have the right

*to be informed of any breach of their unprotected PHI;
*to have marketing communications made to them only if authorized by the patient;
*to decline to have PHI delivered to health insurers if the patient pays for services in full without submitting a claim.
*to contact the Practice HIPAA Compliance Officer, _____, at (555) 555-5555.

Patient Signature: _____

Date: _____