HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
4. You agree to bring any concerns or complaints regarding privacy to the attention of the office staff or the doctor.
5. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
6. We agree to provide patients with access to their records in accordance with state and federal laws.
7. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ (date) _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

HIPAA AUTHORIZATION

In compliance with Chiropractic and Acupuncture Wellness Center (CAWC) this form will allow you to designate an individual(s) to whom CAWC may disclose your protected health information. This may include individually identifiable information related to past, present or future appointment, medical or financial information. If you do not want to designate an individual(s) to receive your protected health information, indicate "none" below.

Patient Name:_____

Date of Birth: _____

Address:_____

City:_____State:_____Zip:_____

Telephone Number: (_____)_____

I do hereby authorize CAWC to disclose protected health information to the following:

1. _____(___) _____
Name / Relationship to patient / Telephone number

2. _____(___) _____
Name / Relationship to patient / Telephone number

3. _____(___) _____
Name / Relationship to patient / Telephone number

By signing below I acknowledge that I have had full opportunity to read and consider the content of this authorization and understand that my protected health information may be disclosed to the individual(s) listed above. I understand that designating the individual(s) listed above does not exclude CAWC from disclosing my protected health information as outlined by CAWC.

I understand that I have the option to revoke this authorization at anytime at which time I can execute a new authorization. I also understand that unless revoked in writing by completing a new authorization form, this authorization will remain in effect until I choose to revoke it.

_____
Patient Signature / Date

_____
Personal Representative (Relationship to Patient) / Date