Blue Skies Center for Women

HIPAA PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize Blue Skies Center for Women to use and disclose my protected health information (PHI) to carry out the following:

- Treatment (including direct or indirect treatment by others healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of Blue Skies center for Women.

I have also been informed of, and given the right to review and secure a copy of the Blue Skies Center for Women Notice of Privacy Practices, which contain a more complete description of the uses and disclosures of my PHI and my rights under HIPAA. I understand that Blue Skies Center for Women reserves the right to change the terms of this notice at any time and that I may contact Blue Skies Center for Women at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the revocation date is not affected.

Date Signed: _____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

I wish to be contacted in the following manner ***be sure to fill in contact phone numbers***. If you do not accept blocked calls, any return call may be delayed, unless you remove this feature from your phone.

□ **Home Telephone #** _____

□ Can leave a message with detailed information
OR
□ Leave a message with a call back number only

□ **Work Telephone #** _____

□ Can leave message with detailed information
OR
□ Leave a message with a call back number only

□ **Alternate Telephone #** _____

□ Can leave a message with detailed information
OR
□ Leave a message with a call back number only

□ **Written Communication**

□ Can send letter with detailed information
OR
□ Okay to fax to this number _____

PLEASE INDICATE WHO WE CAN SPEAK TO REGARDING YOUR MEDICAL INFORMATION:

□ Patient only

□ Spouse or Significant other Name_____ Phone _____

□ Parents Name _____ Phone _____

□ Other Name_____Phone _____

Other Comments: _____

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