Axia Women's Health

HIPAA
Acknowledgments and Authorizations

I. HIPAA Notice of Privacy Practices

Patient Acknowledgment

Axia is required by law to maintain the privacy of protected health information and provide individuals with notice of their legal duties and privacy practices with respect to protected health information. If I have any questions, I understand I can speak with the HIPAA Compliance Officer in person or by phone.

Signature below is only acknowledgment that I have been given the option of receiving a copy or been afforded an opportunity to review Axia's Notice of Privacy Practices:

Print Name: _____ Date of Birth: _____ Date: _____

Signature: _____

II. Authorization for use or Disclosure of Health Information

Patient Contact Information

I authorize **brief messages** with medical information to be left on voicemail at (check all that apply): ☐ Home ☐ Cell ☐ Work

I authorize **extended messages** with medical information to be left on voicemail at (check all that apply): ☐ Home ☐ Cell ☐Work

Restrictions/Instructions: _____

Release of Medical History and Treatment Information

I authorize the following individual(s) to receive information pertaining to any medical history and treatment received:

☐Please use my emergency contact on the patient demographic form.

Name: _____ Relationship: _____ Ph #: _____

Name: _____ Relationship: _____ Ph #: _____

The above individual(s) may receive information across all Axia care centers unless otherwise noted: _____

Release of Billing Information

I authorize the following individual(s) to receive information pertaining to any billing issue and to act on my behalf:

☐Please use my emergency contact on the patient demographic form.

Name: _____ Relationship: _____ Ph #: _____

Name: _____ Relationship: _____ Ph #: _____

The above individual(s) may receive information across all Axia care centers unless otherwise noted: _____

Parent / Guardian Information

Contact: _____ Relationship to You: _____

Home Phone: _____ Alt. Phone: _____

Contact: _____ Relationship to You: _____

Home Phone: _____ Alt. Phone: _____

Patient Acknowledgment

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance with the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office address. My revocation will be effective once received by the practice, an Axia Women's Health Care Center.
2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Print Name: _____ Date: _____

Signature: _____ Relationship: _____

Additional Authorizations

I request a female chaperone to be present during my examination? ☐ Yes ☐ No ☐ Other _____