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HIPAA Acknowledgments and Authorizations

HIPAA Notice of Privacy Practices

Axia is required by law to maintain the privacy of protected health information and provide individual 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.

Authorization for use or Disclosure of Health Information

Patient Contact Information

Home #: __________________________ Cell #: __________________________ Work #: ___________________ Ext ____

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:

Name: ____________________________________ Relationship: ____________________ Phone #: _________________________

Name: ____________________________________ Relationship: ____________________ Phone #: _________________________

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:

Name: ____________________________________ Relationship: ____________________ Phone #: _________________________

Name: ____________________________________ Relationship: ____________________ Phone #: _________________________

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

Parent/Guardian Information

Name: ____________________________________ Relationship: ____________________ Phone #: _________________________

Name: ____________________________________ Relationship: ____________________ Phone #: _________________________

Additional Authorizations

I request a female chaperone to be present during my examination. YES NO Other_________________________________

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 effective as the original

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

My signature below is 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. In addition, my signature authorizes disclosures per above.

____

Patient/Authorized Signature Relationship

____

Printed Name Date