



# Addison Internal Medicine

## Patient HIPAA Form

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

### Notice of Privacy Practices Acknowledgement

\_\_\_\_\_ (Patient initials) I acknowledge that I have received Addison Internal Medicine Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Addison Internal Medicine Notice of Privacy Practices.

### Release of Information

\_\_\_\_\_ (Patient initials) I permit the practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment or healthcare operations.

- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse’s notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

### Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone No.: \_\_\_\_\_
2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone No.: \_\_\_\_\_
3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone No.: \_\_\_\_\_

\_\_\_\_\_  
Patient (or responsible party) Signature

\_\_\_\_\_  
Date