Comprehensive Cardiovascular

Leading the fight against heart disease

HIPAA PRIVACY FORM

Patient's Name:____

Address:______________________City:______________________________

CA, Zip______________________Phone (   )______________Fax(   )______________

Privacy Officer (**PO**): Patti Emerson (661) 631-5544 ext. 107
Practice Manager (**PM**): Teresa Blevins (661) 631-5544 ext. 104

- Posted in our lobby is our *Notice of Privacy Practices.* It provides information about how our office may use and disclose your Protected Health Information (PHI);

You have the right to review our Notice of Privacy Practices before signing this *Patient Consent Form.* Please take the time to do so now. A copy is attached.

You have the right to request that we restrict how your PHI is used or disclosed for Treatment, Billing/Payment, or Medical Office Operations. *Request for Restriction of PHI* must be submitted to the **PM** in writing and signed by you as specified in our Notice;

- Our office does not have to agree with your *Request for Restriction of PHI.* If we agree to your *Request for Restriction of PHI,* we shall honor that agreement.

You have the right to revoke this *Patient Consent Form. Revocation of Consent* must be submitted to the **PM** in writing and signed by you as specified in our *Notice;*

- A *Revocation of Consent,* does not affect disclosures made prior to the date the *Revocation* was made.

- Our *Notice of Privacy Practices* may change from time-to-time. If it does, you will receive a "revised" *Notice* on the first visit after changes to the *Notice* were made.
- **Your signature below** signifies your consent to the use and disclosure of your PHI by our office during treatment, Billing/Payment, and Medical Office Operations as outlined in our Notice.
- Our office may condition treatment upon execution of this *Patient Consent Form.*
- This Form is provided to you so that our office may comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This Patient Consent was signed by:______________________ ______________________
(Print Name of Patient or Representative) (Relationship to Patient)

______________________ ______________________
Patient's Signature Date

Witnessed by: Patti Emerson or Teresa Blevins — Privacy Officer or Practice Manager
(Print Name of Privacy Officer or Practice Manager) (Title)

______________________ ______________________
Signature Date

Confidential Channel Communication Request

Patti Emerson, Privacy Official
(661)631-5544 ext. 108

I,___________________________(print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment.

This request supersedes any prior request for confidential channel communications I may have made.

Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

I want you to contact me by telephone at____

Do Do not leave messages on my answering machine.

Do Do not leave messages with any other person.

I want you to contact me at the following address:____

____

Other Restrictions

____

____

I will be responsible for communicating any changes or new restrictions to your office in writing.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You have the right to refuse to sign this Acknowledgement

I,_____________________________________ have received a copy of this office's
(Signature of Patient or Parent/Guardian)

NOTICE OF PRIVACY PRACTICES as required by federal law.

____
Print Patient's Name

____
Signature of Patient or Parent/Guardian