OCOTILLO INTERNAL MEDICINE
HIPAA Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

Patient Name: _____ Date of Birth: _____

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient hereby waives his/her confidentiality rights should collection action become necessary. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office. However, we are not obligated to alter internal policies to conform to your request.

My protected health information can be released to the following people:

Name: _____ Relationship: _____Phone:_____

Address:_____

Name: _____ Relationship: _____Phone:_____

Address:_____

Name: _____ Relationship: _____Phone:_____

Address:_____

HIV/AIDS/STD: This form authorizes release of medical information including HIV-related. Confidential HIV-related information is any information indicating that a person has had an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or any information that could indicate a person has been potential exposed to HIV. I **DO ___ DO NOT ___** consent to the release of any positive or negative test result for AIDS/ HIV or STD infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:____ Date: _____**

With this consent, I give Ocotillo Internal Medicine permission to call my home or other alternative location provided in patient information form and leave a detailed message on voice mail or in person to someone listed above in reference to any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care such as lab and test results.

_____ _____

Patient Signature [or parent, guardian or legal representative] **Date (expires in 1 year)**