Brushy Creek Family Physicians Patient HIPAA Acknowledgment and Consent Form

(Patient initials) Notice of Privacy Practices. acknowledge that I have received the practice of Notice of Privacy Practices, with describes the verys in which the practice may use and disclosures. Interest information for its treatment, payment, hadithcate 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 I jaw, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices. (Patient initials) Rolease of Information. I hereby permit practice and the physicians or other health professionals involved in the impatient or outpetient care or for case management purposes of treatment, payment, or healthcare operations. Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity lable for payment on the Patients behalf in order to verify overlage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered air related to a claim under worker's compensation. If I am overed by Medicare or Medicael, I authorize the release of healthcare information to the Social Security Administration or a compensation of the Social Security Administration or a compensation of the Social Security Administration or treatment and discharge summany. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care information in payment of a Necleosial calm. This information and discharge summany. Federal and state laws may permit this facility to participate in organizations with one another to ac	Patient Name:		Date of Birth:	
involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information regarding a prior admission(s) at other HCA affiliated afacilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermedianes or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicare claim information may include, without limitation, history and physical, emergency records, laboratory ports, physician progress notes, nurse's notes, consultations, psychiological 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 sume needed to access my information, agengestic mide companing my information for quality improvement purposes, and such other purposes as may be permitted by law. I understand that this inclin my be disclosed to the purpose of communication in internation and the provider in information of the purposes of communication in internation and the provider in information in internation and previous including, but not l	Practices, which describes the ways in w payment, healthcare operations and other Privacy Officer designated on the notice if	which the practice may use and disclose my r described and permitted uses and disclos f I have a question or complaint. To the exte	y healthcare information for its treatment, ures, I understand that I may contact the ent permitted by law, I consent to the use	
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