

Integrated Psychiatry

HIPAA Information and Consent Form

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

Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services.

HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

By signing this form, I understand that:

- 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.
- It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you.
- 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 concerning your PHI.
- We agree to provide patients with access to their records in accordance with state and federal laws.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

I, _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature _____

Date _____