HIPAA Acknowledgment and Consent Form

Elite Women's Care			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice

_____ (**Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic 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. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates to the extent permitted by law. I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM 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:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

_____ (**Patient/Representative initials)** I consent to receiving instructions and other healthcare communication at the email or phone number I have provided. **Preferred method of contact:** Email _____ Phone _____

Release of Information

- Your confidential healthcare information may be released to: other healthcare professionals within the organization for the purpose of providing you with quality healthcare, with your insurance provider for the purpose of the organization receiving payment, public or law enforcement officials in the event of an investigation or lawsuit, other healthcare providers in the event of your emergency care, public health or federal organization in the event of a communicable disease.
- 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 HIV and AIDS.
- Your confidential healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your confidential healthcare information may be released only after receiving written authorization from you. This provision includes but is not limited to any psychotherapy notes, for marketing purposes and any disclosures that may constitute a sale of your protected healthcare information. Any other uses or disclosures that may constitute a sale of your protected healthcare information. Any other uses or disclosures not described in this notice can only be made with your express authorization. You may revoke your permission to release confidential healthcare information at any time.
- You have the right to opt out of notifications regarding healthcare treatment options, marketing and fundraising, or other health services that might be of interest to you.
- You have the right to restrict the use of your confidential healthcare information. However, the organization may choose to refuse your restriction if it's in conflict of providing you with quality healthcare or in the event of an emergency.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of electronic transmission or paper.
- The organization is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information.
- The organization will promptly contact you should there be any breach of your protected health information.
- The organization will abide by the terms of this notice. The organization reserves the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.
- You have the right to complain to the organization if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail, in writing, your complaint to the organization's Privacy Officer Lindsey Wisniewski at 11319 Cortez Blvd. Brooksville FL, 34613.
- All complaints will be investigated. No personal issue will be raised for filing a complaint with the organization.
- For further information about this Privacy Notice, please contact: Melissa Jordan, Practice Manager.
- This notice is effective as of 10/16/2013. This date must not be earlier than the date on which the notice is printed or published.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient	Date