

HIPAA Acknowledgements and Authorizations

I. HIPAA Notice of Privacy Practices

Patient Acknowledgement

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have been given the option of receiving a copy or been afforded an opportunity to review our Notice of our Privacy Practices:

Print Name: _____

Date of Birth: _____

Signature: _____

Date: _____

II. Authorization for use or Disclosure of Health Information

Patient Contact Information

Home #: _____ Cell #: _____ Work #: _____ Ext: _____

I authorize Brief messages with medical information to be left on voicemail at (check all that apply): Home Cell Work

I authorize Extended messages with medical information to be left on voicemail at (check all that apply): Home Cell Work

Restrictions/Instructions: _____

Release of Medical and Billing Information

I authorize the following individual(s) to receive information pertaining to any medical history, treatment received and billing matters:

Name: _____ Relationship: _____ DOB: _____ Ph #: _____

Restrictions: _____

Electronic Communications

Portal: We offer secure electronic communications between you and our office via our Patient Portal. Secure messages and information can only be read by someone who knows the right password to log in to the Portal site. The communications are automatically encrypted and for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information.

Yes, I want to participate, please use the email provided on my HIPAA form.

No, I do not wish to participate.

Automated Calls: As an added convenience, we offer automated appointment reminders via a text message or an automated call for those who want to participate. The reminders are sent from a computer and cannot be used as a way for you to communicate back to us. If you should need to reach us, please call our main number. If at any time you should change your mind, please let us know what other method you would prefer for appointment reminders.

I understand under the telephone consumer protection act, that in order for you to contact me by automated means for services relating to my medical care, including appointment reminders, monies I may owe, etc., I agree that Axia Women's Health and/or your agents may contact me by my cell phone, which may result in charges to me. You may also contact me by text messages, or emails providing that I have consented above. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automated dialing device, as applicable.

Yes, I agree to participate in automated dialing, my cell number is provided below.

Cell Phone Number: _____

No, I do not wish to participate.

Patient Acknowledgement

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to our office address. My revocation will be effective once received by the practice, an Axia Women's Health Care Center.

2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Print Name: _____

Date: _____

Signature: _____

Relationship: _____