

ConwayUrology

HIPPA Consent Forms

HIPAA GENERAL CONSENT

I hereby give my consent for Conway Urology and its associates to use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operations. I understand that my Protected Health Information is as follows:

Information that is oral or recorded in any form that relates to my past, present, or future, physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.

This Protected Health Information could include information that this Health Care Provider created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I have been informed that my Health Care Provider has adopted a complete statement of its privacy practices, which are contained in Conway Urology Notice of Privacy Practices. I understand that my Health Care Provider has the right to change them at any time without advance notice to me. I can request a copy of my Health Care Providers latest Notice of Privacy Practices by calling the office, stopping by and picking up a copy, by reading the Notice that is posted in my Health Care Provider' s waiting room, or asking that my name be put on a list to be mailed a copy of any updated Notice of Privacy Practices should my Health Care Provide make changes to the Notice of Privacy Practices.

I understand that I have the right to not give this consent; however, I also understand that my Health Care Provider does not have to treat me if I do not sign this consent.

I understand that I have the right to request restrictions on this consent and to request limits on when and how my Health Care Provider uses and discloses my Protected Health Information, however, I understand my Health Care Provider is not obligated to agree to the restrictions or limitations I request.

I understand that if my Health Care Provider agrees to a restriction, my Health Care Provider shall be bound by the restriction until I release my Health Care Provider from that restriction.

GENERAL AUTHORIZATION

I specifically give this Health Care Provider authorization to use or disclose my Protected Health Information to other health care providers, group health plans, and business associates to provide for my medical care, treatment, and evaluation; the payment of my medical care, treatment, and evaluation; and to provide information for utilization and quality care purposes.

I understand that I have the right to request in writing to inspect and copy my Protected Health Information. There are a few exceptions to this rule. My health Care Provider must approve or deny my request within 30 days and in the case of a denial, provide me an explanation of the reason.

SPECIFIC AUTHORIZATION

I hereby give my authorization for Conway Urology to use or disclose my Protected Health Information to carry out treatment, payment, or any other health care operations.

I understand that my Protected Health Information is as follows:

Information that is oral or recorded in any form that relates to my past, present, or future, physical or mental health condition, my past, present, or future health care treatment, or the payment of my past, present, or future health care treatment, that is or could reasonably identify me and is transmitted in an electronic form or maintained in any form.

This Protected Health Information could include information that this Health Care Provider created, received from me, received from another Health Care Provider, received from a Health Plan, Health Care Clearing House, Insurance Company, Employer, or any other source, and could include demographic information about me.

I specifically give this Health Care Provider authorization to use or disclose my Protected Health Information to the following persons for the following purposes:

I hereby consent to all the uses and disclosures in my Health Care Provider' s Notice of Privacy Practices. I understand that I have the right to revoke my authorization; however, it shall not be considered revoked to the extent my Health Care Provider has relied on it. I understand that once this information has been disclosed to third parties, there may not be any safeguards to prevent the third party from further disclosing the Protected Health Information.

I request this authorization expire on the following date: _____. I may revoke it sooner in writing by contacting the Privacy Official Melany Forsberg, I may also reach him/her by phone at 501-327-5850. I understand the Health Care Provider can condition my treatment or evaluation on my signing this authorization.

Patient – Printed Name

Patient Signature

Date

Personal Representative of Patient