
# PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

## Notice of Privacy Practice:

I understand that this information may be disclosed electronically by the Provider. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice Notice of Privacy.

## Disclosures to Friends and/or Family Members

Do you want to designate a family member or other individual with whom Far North Surgery clinical team may discuss your medical condition?

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 | | | |

**Consent to Email, Cell Telephone for Appointment Reminders and/or Healthcare Communications:**

We want to stay connected with our patients. Patients in our practice/clinic may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice.

**I authorize** to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information via cell#: _____

**I authorize** to receive email messages for appointment reminders and general health reminders/feedback/information via email: _____

***Note:*** *This practice uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided.*

## Release of Information:

I hereby permit practice and **Madhu Prasad, MD** or other clinical healthcare professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- __Healthcare information regarding a prior service(s) at other providers may be made available to subsequently coordinate care. 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 intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, and discharge summary.

**Patient/Representative Signature: _____ Date: _____**

**Patient/Representative Signature (Printed): _____**

**Date of Birth: _____**