

StDavid's HEART & VASCULAR

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name (Printed): _____ Date of Birth: _____

Notice of Privacy Practice/clinics.

_____(Patient/Representative initials) I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, 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 practice/clinic's Notice of Privacy Practice/clinics.

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.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent _____ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

-OR-

I do not consent _____ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities).

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other 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, and to be provided general health reminders/information. 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/clinic. You may opt out of these communications at any time (see next page). The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I authorize to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and **the cell phone number is** _____.

I authorize to receive email messages for appointment reminders and general health reminders/feedback/information and **the email that is** _____.

-OR-

I decline _____ (Patient/ Representative Initials) to receive communication via text.

I decline _____ (Patient/ Representative Initials) to receive communication via cellular telephone call.

I decline _____ (Patient/ Representative Initials) to receive communication via email.