Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of hearth information about me patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patient), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent

If you have any objections to this form, please ask to speak with our HfPAA Compliance Officer. You have the right to review or privacy notice, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice.

PRINT NAME: _____

SIGNATURE: _____ **DATE:**

I give permission to _____ to
_ receive and/or discuss my medical Information with Dr. Victoria *4.* Mondloch.

NOTES: We are considered a specialist not a primary physician office, therefore, your co-pay will reflect as specialist, possibly noted on your insurance card. If you do not pay that co-pay you will be billed from our billing office for that remaining balance. If there are any questions please contact your insurance company for further information.

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our Valued Patient:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and. doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to property determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in anyway to the growing " problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will.help us prevent any inappropriate use of PHI. We also know that we are not perfect. Because of this met, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem, that we may remedy the situation promptly.

THANK YOU FOR BEING ONE OURHIGHLY VALUED PATIENTS...