Office Use Only - Account Number: _____ Eff: 12/20/2017

Sammy Lerma III, M.D. P.A.

HIPAA Compliance Patient Consent Form

Our *HIPAA Notice of Privacy Practices* provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You agree by your signature that you have received our notice before signing this consent. The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you voluntarily consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, you understand that:

- Protected health information will be disclosed or used for treatment, payment, or healthcare provisions.
- Our practice reserves the right to change the privacy policy as required by law.
- Our practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will cease.
- Our practice may contact you for scheduling purposes, appointment reminders, payment reasons, or other aspects of your care. Unless you give written notification otherwise, we will leave a message on your answering machine/voice message or with someone who answers your phone, if you are not available.

FOR PATIENT COMPLETION:

May we discuss your medical condition with any member of your family or another individual? ☐ Yes ☐ No
IF YES, please name the individuals allowed:

Name:	Date of Birth:	Relationship:	Phone #:
Name:	Date of Birth:	Relationship:	Phone #:
Name:	Date of Birth	Relationship:	Phone #:

Check the box of the information to be released:

☒ **All medical records** (including patient histories, office notes (except psychotherapy notes), test results, radiology studies, referrals, consults, billing/insurance records, and records received from other healthcare providers)

OR:
☒ Medical record from _____ (date) to _____ (date) (including patient histories, office notes (except psychotherapy notes), test results, radiology studies, referrals, consults, billing/insurance records, and records received from other healthcare providers)

CHECK WHICH SPECIAL INFORMATION YOU WANT TO RELEASE:

☒ Drug, alcohol or substance abuse records	☒ Mental Health records (except psychotherapy notes)	☒ HIV/AID-related information (including HIV/AIDS test results)	☒ Genetic information (including genetic test results)

This consent was signed by: _____ (PRINTED PATIENT NAME)

Signature of Patient: _____ Date: _____

Office Witness Signature: _____ Date: _____