Patient Health Information Consent Form

=You may refuse to sign this acknowledgement=

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning thie privacy of your Patient Health Informationn, we encourage you to read the HIPAA NOTICE that is available to you by request before signing this consent.

1. The patient understands and agrees to allow this MAT Specialist and this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient's PHI will not be shared with any 3rd party or individual unless consent is given below.

5. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent, but would apply to any care given after the request has been presented.

6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do no need them.

7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the MAT Specialist has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____	_____
Printed Name	Signature
_____	_____
Date	Please release my PHI to the above person(s)

_____

For Office Use Only

We attempted to obtain written consent of our Notice of Privay Practices, but consent could not be obtained because:

____ Individual refused to sign ____ Communication barriers prohibited obtaining consent ____ Emergency situation prevented obtaining consent

Other _____