ANDERSON MEDICAL GROUP
OF TEXAS
YOUR HEALTH. OUR CARE.

Patient HIPAA Consent Form

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance to your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

I authorize that your office may contact me in the following manner (check all that apply):

Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Email ☐

I give the Anderson Medical Group of Texas, PLLC. (AMG) permission to email my laboratory results or clinical information to me at the listed email address. I understand that email is not a secure route of delivering information and may be viewed by other individuals. I will not hold AMG responsible for any information pertaining to my health records being viewed by unauthorized individuals.

Patient Initials _____

NOTICE OF PRIVACY PRACTICES

Consent to the use & disclosure of healthcare information for treatment, payment, or healthcare operations and acknowledgment of receipt of notice of privacy practices

I understand that as part of my healthcare, **Anderson Medical Group of Texas** originates and maintains health records describing my history, symptoms, examination and test results, diagnosis, treatment, and plans for future care of treatment.

I understand that this information serves as:

A basis for planning my care and treatment. A means of communication among the healthcare professionals who contribute to my care. A source of information for applying my diagnosis and medical services information to my bill. A means by which a third-party payer can verify that services billed were actually provided. A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right to:

Request restrictions as to how my information may be used or disclosed to carry out treatment, payment, or healthcare operations (see below), and that the Anderson Medical Group of Texas is not required to agree with the restrictions requested, in which case I will be notified. Revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon.

I request the following restrictions to the use of disclosure of my health information: (Please list below)

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I have read the **PATIENT HIPPA CONSENT FORM** and received a copy of **Anderson Medical Group's NOTICE OF PRIVACY PRACTICES**.

Patient Name	Signature of Patient	Date

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices but:

- ☐ Individual refused to sign ☐ An Emergency precluded obtaining the acknowledgment
- ☐ Communication barriers precluded obtaining the acknowledgment
- ☐ Other_____