

Patient HIPAA Consent Form

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

We respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary, we will provide requested information only to those who, we feel, are in need of it in order to facilitate the health care that is in your best interests. Some providers may have indirect treatment relationships with you (such as laboratories). These entities are most often not required to obtain patient consent beyond the one given to us.

You may refuse to consent to disclosure of your personal health information. This must be done in writing. Under the law, we have the right to refuse to treat you if you choose to exercise this option. You may also choose to request the termination of personal information sharing (completely or in part)at a later date. This must also be done in writing. You may not revoke actions that have already been taken which relied on this or other previously signed consent.

You have the right to review our full text copy of HIPAA Notice. The Staff will gladly provide you with one upon request. Please keep it for future reference.

Your signature below authorizes the release of necessary medical information. Your signature below acknowledges understanding of HIPAA policy as applicable to Friedman Surgical Group, PC and your treatment.

X _____ Date _____
patient/ responsible party
(if patient is a minor, must be signed by parent or guardian)

Patient/ Responsible Party Financial Agreement

I authorize the payment of medical benefits to the Friedman Surgical Group, PC, for the services provided. In the event my health plan(s) does not cover a service and/ or fee, I agree to pay for all deductibles, co-payments, non-covered services, and any portion of covered services not paid in full by my health plan(s). I understand that such payments are due at the time of service or immediately upon presentation of the bill.

X _____ Date _____
patient/ responsible party
(if insured is a minor, assignment must be signed by parent or guardian)

Revised: May 5, 2017