associates in PRIMARY CARE

ACKNOWLEDGEMENT OF PRIVACY PRACTICES PATIENT CONSENT FORM

I agree that I shall be legally responsible for any medical or surgical charge incurred in excess of any hospitalization or health insurance that might be applicable. I assign payment of authorized benefits to *Associates in Primary Care* on my behalf for services rendered. I understand that I am responsible for the charges not covered by the policy.

RELEASE OF INFORMATION

I authorize *Associates in Primary Care* to release any medical information required by my health insurance company to process a medical claim.

I authorize *Associates in Primary Care* to release any medical information requested by my specialist to process with the care for my health and safety.

CONSENT TO TESTING

In connection with certain diagnostic tests, I understand that specimens of blood and urine and other bodily fluids, tissues or products may be obtained, and that test will be performed upon such fluids, tissue, and products, and I consent to this. I understand that if it becomes necessary that I be tested for antibodies to Human Immunodeficiency Virus (HIV), I will be counseled by my physician and I will be given the choice of consenting in writing to such testing. I have been informed that my written consent to testing for HIV antibody or other communicable diseases is not required by law in situations where a healthcare provider sustains an exposure to blood or body fluid.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. 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 want you to know that we support your full access to your personal medical records. When it is appropriate and necessary, we provide the minimum necessary 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. You may refuse to consent to this 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. If you choose to give consent in this document, at some future time you may request to refuse all or part of your Personal Health Information. 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 HIPAA Compliance Officer.

Signature below is my acknowledgement of above Privacy Practices and Consent, I hereby allow *Associates in Primary Care* to use my Personal Health Information as stated above.

_____ _____

Signature (First, Last Name) Date

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