HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA), provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services: **www.hhs.gov**

We have adopted the following policies (Please initial, sign, and date below):

____Patient information will be kept confidential except as is necessary to provide services to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for our care. Patient records will not be available to persons other than office staff unless permission is granted otherwise by you in writing. You agree to the normal procedures utilized within the office for the handling of patient records, PHI and other documents or information.

____It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail or by any means convenient for the practice and /or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

____The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

____You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

____You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

____Your confidential information will ***not*** be used for the purposes of marketing or advertising of products, goods or services.

____We agree to provide patients with access to their records in accordance with state and federal laws.

____We may change, add, delete or modify any of these provisions to better serve the needs of both the patient and the practice.

____You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, ____ hereby consent and acknowledge my agreement to the terms set forth above and any subsequent changes in office policy.

____***Date:*__________**

Signature & Date (Parent/Guardian if minor)

Laura Murphy Orofacial Myofunctional Therapist Laura@wellnessmyo.com 512.676.9444