Patient Consent for the Disclosure of Information and Acknowledgement form (HIPAA)

I understand that by signing this form I consent to the following:

1) Sharing information for the purpose of treatment: You will share my information with all members of my treatment team, both within the office and with other providers (personal and institutional) in order to provide me with the quality care and the educational/wellness programs specified in my insurance plan. This will include communication with our team in verbal and non verbal form such as post card reminders, recognition boards, sign in information and other forms of communication for patient care and office visits.
2) Sharing information for purposes of payment: You will share all necessary information with my insurer(s), governmental entities and their representatives (including but not limited to) claim representatives, data warehouses, billing companies or finance companies, and in extreme situations, credit bureaus or collection agencies.
3) Sharing of information for purposes of operations: You will share all information necessary for ongoing operations of this office, including (but not limited to) credentialing processes, peer review, non-facial images for website purposes, and accreditation and compliance with all federal and state laws.

I also understand that by signing this form I give this office permission to leave messages on my answering machine, voicemail, e-mail, or personal contact via the telephone regarding: notifications of appointments, messages to call the office, test results and any other information pertaining to my healthcare with the office.

Information may be left with:______________________________________ at my home number or at another location. I understand that you will be unable to release the information to anyone other than the person/persons listed above.

My consent is freely given. I understand that I may revoke this consent at any time that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

______________________________ ______________

Patients name (printed) Date

______________________________ ______________

Patients Signature (guardian, if minor) Date

______________________________ ______________

Witness Date

I have read and been offered/given a copy of the Notice of Privacy Practices for Dr. Robert Cady

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