HIPPA CONSENT FORM

I_______________________________, UNDERSTAND THAT AS PART OF MY HEALTHCARE, DR. GRECO ORIGINATES AND MAINTAINS PAPER AND/OR ELECTRONIC RECORDS DESCRIBING MY HEALTH HISTORY, SYMPTOMS, EXAMINATION, DIAGNOSES, TREATMENT AND ANY PLAN FOR FUTURE CARE OR TREATMENT. I UNDERSTAND THAT THIS INFORMATION SERVES AS:

- A BASIS FOR PLANNING MY CARE AND TREATMENT.
- A MEANS OF COMMUNICATION AMONG THE MANY HEALTH PROFESSIONALS WHO CONTRIBUTE TO MY CARE.
- A SOURCE OF INFORMATION FOR APPLYING MY DIAGNOSIS AND TREATMENT INFORMATION TO MY BILL.
- A MEANS BY WHICH A THIRD-PARTY PAYER CAN VERIFY THAT SERVICES BILLED WERE ACTUALLY PROVIDED.
- A TOOL FOR ROUTINE HEALTH CARE OPERATIONS SUCH AS ASSESSING QUALITY AND REVIEWING THE COMPETENCE OF HEALTHCARE PROFESSIONALS.

I UNDERSTAND AND HAVE BEEN PROVIDED WITH A NOTICE OF PATIENT PRIVACY INFORMATION PRACTICES THAT PROVIDES A MORE COMPLETE DESCRIPTION OF INFORMATION USES AND DISCLOSURES. I UNDERSTAND THAT I HAVE THE FOLLOWING RIGHTS AND PRIVILEGES:

- THE RIGHT TO REVIEW THE NOTICE PRIOR TO SIGNING THIS CONSENT
- THE RIGHT TO REQUEST RESTRICTIONS AS TO HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH
- CARE OPERATIONS

I UNDERSTAND THAT DR. GRECO IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS REQUESTED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING, EXCEPT TO THE EXTENT THAT THE ORGANIZATION HAS ALREADY TAKEN ACTION IN RELIANCE HEREON. I ALSO UNDERSTAND THAT BY REFUSING TO SIGN THIS CONSENT OR REVOKING THIS CONSENT, THIS ORGANIZATION MAY REFUSE TO TREAT ME AS PERMITTED BY SECTION 164.506 OF THE CODE OF FEDERAL REGULATIOINS.

I FURTHER UNDERSTAND THAT DR. GRECO RESERVES THE RIGHT TO CHANGE THEIR NOTICE AND PRACTICES AND PRIOR TO IMPLEMENTATION, IN ACCORDANCE WITH SECTION 164.520 OF THE CODE OF FEDERAL REGULATIONS. SHOULD DR. GRECO CHANGE HIS NOTICE, HE WILL SEND A COPY OF ANY REVISED NOTICE TO THE ADDRESS I HAVE BEEN PROVIDED, BY US MAIL.

I WISH TO HAVE THE FOLLOWING RESTRICTIOINS TO THE USE OR DISCLOSURE OF MY HEALTH INFORMATION:

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MAY WE LEAVE AN APPOINTMENT REMINDER MESSAGE AT HOME USING DOCTORS NAME: YES () NO ()
MAY WE LEAVE AN APPOINTMENT REMINDER MESSAGE AT WORK USING DOCTORS NAME: YES () NO ()
DO NOT LEAVE MESSAGE ()

PLEASE TELL US WITH WHOM WE MAY DISCUSS YOUR TREATMENT, PAYMENT, OR HEALTHCARE OPERATION:

EXAMPLE: SPOUSE, CHILDREN (NAMES), OTHER RELATIVES (NAMES), FRIENDS OR CAREGIVERS (NAME)

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I UNDERSTAND THAT AS PART OF THIS ORGANIZATION'S TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS, IT MAY BECOME NECESSARY TO DISCLOSE MY PROTECTED HEALTH INFORMATION TO ANOTHER ENTITY, AND I CONSENT TO SUCH DISCLOSURE FOR THESE PERMITTED USES, INCLUDING DISCLOSURES VIA FAX.

I FULLY UNDERSTAND AND ACCEPT/DECLINE THE TERMS OF THIS CONSENT.

______________________________ ______________________
PATIENT'S SIGNATURE DATE

FOR OFFICE USE ONLY

() CONSENT RECEIVED BY______________________________ON______________
() CONSENT REFUSED BY PATIENT, AND TREATMENT REFUSED AS PERMITTED