HCA
Physician Services

Commonwealth Perinatal Services - Patient HIPAA Form

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Notice of Privacy Practices Acknowledgement

_____(patient initials) I acknowledge that I have received Commonwealth Perinatal Services Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Commonwealth Perinatal Services Notice of Privacy Practices.

Release of Information

_____ (patient initials) I permit the practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate patient care for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

HCA
Physician Services

Disclosures to Friends and/or Family Members
I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name 1: _____

Name 2: _____

Name 3: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations
_____I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the hospital's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the practice without a specific written authorization from me or my legal representative unless otherwise required by law.

Consent to Receive Text Messages or Emails about Appointment Reminders:
Patients in our practice may be contacted via email or text messaging to remind you of an appointment.
_____ I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive appointment reminders. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing.
The cell phone number that I authorize to receive text messages for appointment reminders is_____.
The email that I authorize to receive text messages for appointment reminders is_____.
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation

I hereby revoke my request for future communications via email and/or text.

__*I hereby revoke my request to receive any future appointment reminders via text messages.*

__ *I hereby revoke my request to receive any future appointment reminders via email.*

NOTE: This revocation only applies to communications from this practice.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ *Time:* _____