Heart of Kansas Family Health Care

HIPAA CONSENT FORM

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of the PHI be made by alternative means such as sending correspondence to the individual's office instead of home. Please see our Notice of Privacy Practices for a full disclosure of how we may use your information, your rights and your responsibilities.

Leave messages on answering machine, voicemail, text or email with detailed protected health information (i.e. lab results, instructions, appointment information) at the following:

Home phone (_____) _____-_____ Work Phone (_____) _____-_____

Cell Phone (_____) _____-_____ Cell Carrier/Service _____

Email _____

I, _____ (patient name) authorize Heart of Kansas to disclose Patient's protected health information (PHI) including appointment information, test results, and other health information to the following individuals upon their request for the purpose of aiding in and/or payment for patient's health care.

Name: _____
Relationship to patient: _____
Address: _____
Phone Number: _____

Name: _____
Relationship to patient: _____
Address: _____
Phone Number: _____

Name: _____
Relationship to patient: _____
Address: _____
Phone Number: _____

This authorization expires upon the date of expressed termination of ongoing medical care and treatment by Patient by Heart of Kansas Family Health Care, Inc. and may be revoked at any time by Patient, or their responsible party, by a writing provided to Heart of Kansas Family Health Care, Inc., except when disallowed as provided in the Notice of Privacy Practices. Heart of Kansas Family Health Care, Inc. may not condition treatment based on the refusal to provide such authorization.

Patient Signature: _____ DOB _____
(If Minor then-)
Parent/legal guardian: _____ Relationship: _____

Date: _____