



# 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 the protected health information (PHI). The individual is also provided with the right to request confidential communications or that 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.

**How would you like to receive the following:** Appointment reminders, Health Notifications, Lab/Test Results, Billing Information. **(Choose any or all options)**

**Consent to Calls:**      **Yes/No**      **Phone Number:** (    ) \_\_\_\_\_ **Best time to call :** \_\_\_\_\_

**Text messages:**      **Yes/No**      **Phone Number:** (    ) \_\_\_\_\_

**Email/Patient Portal:** **Yes /No**      **Email Address:** \_\_\_\_\_

I, \_\_\_\_\_ (patient name) authorize Heart of Kansas to disclose Patients' 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 : \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

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 \_\_\_\_\_

Parent/legal guardian of Minor: \_\_\_\_\_ Relationship: \_\_\_\_\_

Date: \_\_\_\_\_