

HIPAA and Consent Form

ID _____

Read each section and mark all boxes that apply. **At least one box should be marked in each section.**

Our office provides a copy of our Privacy Practices upon the first visit for new patients. We also post copies around the office for patient access.

Notice of Privacy Practices

I have been provided and have reviewed the Notice of Privacy Practices of this office

Patient Portal

The Patient Portal Application Programming Interface (API) provided by our office is an online service of no charge to the patient which allows for seamless electronic communication of Patient Health and Financial Records using a certified secure environment. Activation of the Patient Portal requires the patient to provide a personal email address.

Patient Portal Access (select the best option)

- NO, I would not like access, please Opt Out
 YES, I already have access and have logged on
 YES, I would like access with this email address: _____

Our office will sometimes need to contact the patient via telephone with information regarding appointments and medical concerns. We will only attempt to call the patient at phone numbers approved by the patient, and we will only leave a detailed message if the patient gives consent.

Contact Info

My Contact Number required

() - Mobile Home Work

- NO, Don't leave a message
 YES, you may leave a detailed message

Other Contact optional Name: _____

Relationship: _____
() - Mobile Home Work

Release Medical Info Release Financial Info

Other Contact optional Name: _____

Relationship: _____
() - Mobile Home Work

Release Medical Info Release Financial Info

Other Contact optional Name: _____

Relationship: _____
() - Mobile Home Work

Release Medical Info Release Financial Info

Medical Imaging

Our office may request to take a patient's photo to assist with demographic identification and/or clinical assessment. The patient will not receive payment from any party. Refusal to consent to medical imaging will in no way affect medical treatment.

Medical Imaging Consent (select the best option)

- NO, I do not want my picture taken for use in my Medical Profile or Chart
 YES, I consent to have my picture taken for use in my Medical Profile or Chart

Under the Texas House Bill No. 2561, our office is required to access patient prescription history, which may include prescription details not originating from our office, before prescribing or dispensing controlled substances.

PDMP Acknowledgment

I understand my doctor's obligation to access my prescription history when prescribing controlled substances

I understand I have the right to revoke this authorization at any time and that my revocation must be in writing. I am aware my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have already acted in reliance upon this authorization.

Printed Name: _____

Signature: _____ Date: _____