Southwest Georgia Nephrology Clinic

HIPAA PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize Southwest Georgia Nephrology Clinic to use and disclose my protected health information (PHI) to carry out the following:

- Treatment (including direct or indirect treatment by others healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of Southwest Georgia Nephrology Clinic.

I have also been informed of, and given the right to review and secure a copy of the Southwest Georgia Nephrology Clinic Notice of Privacy Practices, which contain a more complete description of the uses and disclosures of my PHI and my rights under HIPAA. I understand that Southwest Georgia Nephrology Clinic reserves the right to change the terms of this notice at any time and that I may contact Southwest Georgia Nephrology Clinic at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the revocation date is not affected.

I wish to be contacted in the following manner ***be sure to fill in contact phone numbers and check the appropriate line***. If you do not accept blocked calls, any return call may be delayed, unless you remove this feature from your phone.

Home Telephone # _____

___ Can leave a message with detailed information

___ Leave a message with a call back number only

Work Telephone # _____

___ Can leave message with detailed information

___ Leave a message with a call back number only

Alternate Telephone # _____

___ Can leave a message with detailed information

___ Leave a message with a call back number only

Written Communication

___ Can send letter with detailed information

___ Okay to fax to this number _____

PLEASE INDICATE WHO WE CAN SPEAK TO REGARDING YOUR MEDICAL and/or FINANCIAL INFORMATION:

€ **Patient only**

€ Spouse or Significant other Name_____ Phone _____

€ Parents Name _____Phone _____

€ Other Name_____ Phone _____

Other Comments: _____

_____

_____

Printed Name:_____ **Signature:**_____

Date Signed: _____