Clermont MEDICAL CENTER, PA – FAMILY PRACTICE –

3755 S US Highway 27 | Clermont, FL 34711
352-394-4035 | Fax 352-394-8585

HIPAA CONSENT

Authorization for the Use or Disclosure of Health Information

PATIENT INFORMATION

Patient full name (please print) | **Date of birth** | **Medical record number (if known)**

PURPOSE OF THIS CONSENT

Clermont Medical Center, PA creates and maintains paper and electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, plans for future care, and payment for services.

I understand that Clermont Medical Center, PA may use and disclose my protected health information (PHI) to carry out treatment, payment, and health care operations (TPO) as described in the Notice of Privacy Practices.

HOW HEALTH INFORMATION MAY BE USED OR DISCLOSED

- Plan, coordinate, and provide my care and treatment, including communication with health professionals and entities that contribute to my health care.
- Request health information from physicians, dentists, hospitals, laboratories, imaging centers, and other health care entities when needed to plan my care and treatment.
- Verify insurance coverage and submit diagnosis, treatment, and other necessary information to insurers, agencies, or individuals for payment of services.
- Perform health care operations, including quality assessment, staff training, and administrative functions.
- When permitted or required by federal or state law, disclose information that may include HIV/AIDS status, drug or alcohol treatment or abuse notes, and qualified mental health notes to health care providers, health care entities, or others as required by law or court order for treatment, payment, or health care operations.

YOUR RIGHTS

- I acknowledge that I have been provided access to the Notice of Privacy Practices, may request a paper copy at any time, and have the right to read it before signing this consent.
- I may revoke this consent in writing, except to the extent that action has already been taken in reliance on it or as otherwise permitted or required by law.

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COMMUNICATION AND SIGNATURE

COMMUNICATION PREFERENCES

- [ ] You may leave appointment reminders or minimum necessary health or payment information on my answering machine, mobile voicemail, by text or email, or with a family member.
- [ ] Do not leave a message on my answering machine or with a family member.
- [ ] Do not leave a message on mobile voicemail, by text message, or by email.
- [ ] You may send my health information by unsecured email. I understand that email may be accessible by others, and I will send the office an email authorizing transmission to me by unsecured email.

PEOPLE AUTHORIZED TO RECEIVE INFORMATION

I authorize the practice to discuss the minimum necessary health or payment information with the people listed below who are involved in my treatment or payment.

Name	Relationship	Phone number

Name	Relationship	Phone number

Name	Relationship	Phone number

ACKNOWLEDGMENT AND SIGNATURE

I have read and understand this consent, my communication preferences, and the rights and disclosures above. I agree to this authorization.

Patient signature (type full legal name) *

Date *

If someone other than the patient is signing:

Printed name

Relationship to patient

Are you the patient's parent, legal guardian, legal custodian, or health care power of attorney?

- ○ Yes
- ○ No