Barochia Internal Medicine, LLC

Acknowledgement of Receipt of Notice of Privacy Practices
Patient Consent Form

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuel all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Print Name:____

Signed:________________________________Date:_______________________

Relationship (if not signed by patient):___________________________________

I wish to place the following restrictions on disclosure of my health information:

____

I wish to allow the following people access to my medical information:
(Please provide full name and relationship)

____

***Internal Use Only**

If patient/patient’s representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

Presented on (date and time):____
By (name and title):____