Ideal Health Medical Center

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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used at our physical therapy office and your rights concerning these PHI records. Before we begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your PHI records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. You understand and agree to allow our office to use your Patient Health Information (PHI) for the purposes of treatment, payment, healthcare operations, and coordination of care. As an example, you agree to allow our office to submit the requested PHI to the health insurance company (or companies), provided to us by you for the purpose of payment. Be assured that our office will limit the release of all PHI to the minimum, needed for what insurance companies require for payment.
2. You have the right to examine and obtain a copy of your health records at any time and request corrections. You may request to know what disclosures have been made and submit in writing any further restrictions on the use of your PHI. Our office is not obligated to agree to these restrictions.
3. Your written consent needs to be obtained only one time for all the subsequent care given to you at our office.
4. You have the right to provide a written request to revoke the consent at any time during your care at our office. This would not affect the use of those records for the care given prior to the written request to revoke the consent, but would be applied to any care given after the request has been presented.
5. For you security and right to privacy, all staff members have been trained in the area of the patient record privacy and a privacy official has been designated to enforce those procedures at our office. We have taken all the precautions that are known by our office to assure your records are not readily available to those, who are not authorized to have them.
6. You have the right to file a formal complaint with our privacy official regarding any possible violations of these policies and procedures.
7. If you refuse to sign this consent for the purposes of treatment, payment, health care operations, and coordination of care, our office has the right to refuse to give care.

I have read and I understand how my Patient Health Information will be used and I agree to these policies and procedures.

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Name of Patient **Patient/Guardian's Signature**

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