



Evansville Multi-Specialty Clinic, PC

812-475-1948 • Toll Free: 1-888-401-4DOC • Fax: 812-401-1267 • www.evclinic.com

HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers (insurance companies)
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to read and review your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organizations Privacy office to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are required to agree to my requested restrictions, and if agreed then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (printed): _____

Signature: _____ **Date:** _____

Relationship to patient (if minor): _____

PERSONAL HEALTH REPRESENTATIVES AND CONTACT INFORMATION

May we leave a message concerning test results?

On your answering machine? **Yes** or **No**

With another Person? **Yes** or **No**

May we leave a detailed message regarding appointment or billing information?

On your answering machine? **Yes** or **No**

With another Person? **Yes** or **No**

Please list the person(s) with whom we can discuss your protected health information:
