COLLABORATIVE PRIMARY & PSYCHIATRIC HEALTHCARE

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HIPAA PATIENT ACKNOWLEDGMENT & AUTHORIZATION

This form outlines important information regarding how our practice may communicate with you about your healthcare, appointments, billing, and other practice-related matters. By signing this form, you acknowledge that you have reviewed and understand your rights under the Health Insurance Portability and Accountability Act (HIPAA) and that you authorize us to communicate with you via email, phone, and text message. Please carefully review each section of the form, as your signature and initials will serve as your consent to the communication practices described. If at any time you wish to revoke this authorization, you may do so by providing written notice to our office.

Patient Information

Full Name: _____ DOB: _____
Address: _____
Phone Number: _____ Email: _____

Notice of Privacy Practices

_____ ***(Patient/Representative Initials)*** I acknowledge that I have received and reviewed a copy of the Practice's *Notice of Privacy Practices* explaining how the Practice will use and disclose my protected health information ("PHI") for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the privacy officer designated on such notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Practice and/or the Practice's business associates. I understand that the Practice's *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of the current or any revised *Notice of Privacy Practices* upon request. To the extent permitted by applicable law, I consent to the use and disclosure of my information for the purposes described in the *Notice of Privacy Practices*.

Authorization to Use PHI

_____ ***(Patient/Representative Initials)*** I authorize the Practice and its agents to use and disclose my PHI among the Practice, its employee and agents, and/or myself for the purposes contained in the *Notice of Privacy Practices* and for my care and treatment, including:

- Any third-party payer covering my medical services;
- Other health care professionals and institutions in the delivery of health care to me;
- In response to a legally sufficient subpoena or court order;

- Employees and agents of the Practice, to the degree necessary to facilitate the provision of health care services and payment for such services; and
- Otherwise as may be required by applicable law.

Consent to Email, Cell Phone, or Text Message Usage for Appointment Reminders and Other Healthcare Communications

_____ ***(Patient/Representative Initials)*** I consent to the use of email, phone, and text messages as a means of communication with the Practice. I understand that these forms of communication may not be secure, and there is a potential risk that the confidentiality of my health information may be compromised. Despite these risks, I consent to the use of these methods for scheduling appointments, treatment reminders, and other administrative purposes. I understand that I may withdraw this consent at any time by providing written notice to the practice.

I also consent to receiving by telephone call, text message, or voicemail transmission, communications by or on behalf of the Practice at the email, telephone number, or text address I have provided, or any other contact information in my patient record. I consent to receiving such communications to any email, text address, or telephone number forwarded to or transferred from that address or number. Healthcare communications include, but are not limited to, treatment-related messages, appointment reminders, insurance or billing inquiries, and requests for feedback through surveys or public reviews. I authorize that these communications may be made using an automated system for dialing numbers or playing prerecorded messages and may be initiated by the Practice or someone acting on its behalf.

Disclosures to Friends, Family, or Other Designated Representatives

If you would like to designate a friend, family member, or other individual with whom the provider may discuss your medical condition, then please such list below.

_____ ***(Patient/Representative Initials)*** I give permission for my PHI to be disclosed for purposes of communicating results, findings, and other health care decisions to the individuals listed below.

Name	Relationship	Contact Number
1.		
2.		
3.		
4.		

Can we leave a message at the above phone numbers? Yes / No

Emergency Communications

_____ ***(Patient/Representative Initials)*** I understand that in the event of a mental health emergency, the Practice may need to contact me or my designated representative(s) urgently. By initialing, I authorize the Practice to use the contact information I have provided (email, phone, text message) to communicate with me or my designated representative(s) regarding my mental health status, treatment, or urgent care needs during a crisis. I understand that, while the Practice will make every effort to protect my privacy, emergency communication may include sensitive mental health information and may occur through less secure methods (e.g., phone, voicemail, or text message) if necessary to ensure timely intervention.

Additional Acknowledgments

_____ ***(Patient/Representative Initials)*** I understand that I may revoke or modify the authorizations contained herein in writing by contacting the Practice or the privacy officer as stated in the *Notice of Privacy Practices*, except to the extent that information has already been disclosed based on this authorization.

_____ ***(Patient/Representative Initials)*** I understand that the term "protected health information" or "PHI" is individually identifiable information about me, as the patient, and that it includes my past, present, or future healthcare and is transmitted and/or stored by a covered entity or business associate.

_____ ***(Patient/Representative Initials)*** I have had the opportunity to place special restrictions upon the authorizations herein. Any special restrictions are listed as follows:
_____
_____
_____
_____

_____ ***(Patient/Representative Initials)*** I understand that this executed authorization will be stored in my medical record and will be available to me upon request. A copy of this authorization is considered as valid as the original. This authorization does not have an expiration date and will remain in effect until updated or revoked in writing.

***

I certify that I have read and fully understand the statements above on all pages, that I have had an opportunity to ask questions about this form and all of my questions have been answered to my satisfaction, and I consent fully and voluntarily to its contents.

Patient/Representative Signature: _____

Relationship to Patient: _____
(self, representative, guardian, etc.)

Date: _____

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FOR OFFICE USE ONLY

We have made every effort to obtain a written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because (*choose one*):

_____ The patient refused to sign.

_____ Due to an emergency situation it was not possible to obtain an acknowledgment.

_____ We were not able to communicate with the patient.

_____ Other (please specify: _____)

Employee signature: _____

Date:_____