AA care of Georgia, LLC

info@aacareofgeorgia.com

HIPAA Compliance Form

Patient Information:

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Introduction:

This form is designed to inform you, the patient, about the Health Insurance Portability and

Accountability Act (HIPAA) and to obtain your consent for the use and disclosure of your protected health information (PHI) by AA care of Georgia. HIPAA is a federal law that protects the privacy and security of your health information.

What is Protected Health Information (PHI)?

PHI includes any individually identifiable health information, including your medical history,

treatment records, and other health-related information.

Purpose of Consent:

By signing this form, you are giving AA care of Georgia permission to use and disclose your

PHI for the purposes of treatment, payment, and healthcare operations as described below:

1. Treatment: Your PHI may be used by our practitioners to provide, coordinate, or manage your

healthcare and any related services. This includes communicating with other healthcare.

providers involved in your treatment.

2. Payment: Your PHI may be used to obtain payment for the services provided to you.

3. Healthcare Operations: Your PHI may be used for the routine operations of our telehealth clinic such as quality assessment and improvement activities, business management, and

administrative purposes.

Individual Rights Under HIPAA:

You have the right to:

- Request restrictions on certain uses and disclosures of your PHI.

- Receive confidential communications of your PHI.

- Inspect and copy your PHI.

- Amend or correct your PHI.

- Receive an accounting of certain disclosures of your PHI.

- Request a paper copy of this Notice of Privacy Practices.

Privacy and Security Measures:

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AA care of Georgia is committed to maintaining the privacy and security of your PHI. We

have implemented measures to protect your health information from unauthorized access,

disclosure, alteration, and destruction.

Disclosure without Authorization:

In certain situations, AAcare of Georgia may be required to disclose your PHI without your

authorization. These situations include but are not limited to public health activities, law enforcement, and judicial proceedings.

Revoking Consent:

You have the right to revoke this consent at any time. However, revoking this consent will not affect any actions we have already taken in reliance on your prior authorization.

Patient Acknowledgment:

I have received a copy of the HIPAA Compliance Form for AA care of Georgia. I understand the purposes for which my PHI may be used and disclosed and the rights I have under HIPAA. I

hereby give my consent for AA care of Georgia, doing business as GC of Georgia Telehealth to use and disclose my PHI as described in this form.

Patient's Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information:

Aa care of Georgia LLC

info@aacareofgeorgia.com

Clients can contact the practice for additional information or to exercise their rights under

HIPAA.