Emerald Coast Cancer Center
1024 Mar Walt Drive
Fort Walton Beach, FL 32547

HIPAA Consent

Patient Name: _____

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as, sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner (check all that apply):

_____ Home Telephone _____

_____ OK to leave a message with details _____ Leave message with call-back number only

_____ OK to fax to this number

_____ Work Telephone _____ or Work Fax _____

OK to leave a message with details _____ I give authorization for Emerald Coast Cancer Center to leave a message

_____ Leave message with call-back number only my absence _____ OK to send fax to work fax number

_____ Cell Phone _____

_____ OK to leave a message with details _____ My appointment reminders

_____ Leave message with call-back number only _____ my account such as billing and amount due

_____ my treatment/test results

I acknowledge that I have read a copy of the Notice of Privacy Practices for HIPAA.

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep record of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and disclosures for Treatment Records, Payment Information, and Healthcare Operations may be permitted without prior consent in an emergency.

In addition to the authorization for release of my PHI,I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s):

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Patient Signature: _____ Date _____