# Dr. Arthur H. Skalski, M.D.

Internal Medicine F.A.C.S.G.
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## PATIENT HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent

Below is a list of ways the office could contact you. Please check all that apply. Checking a box will give permission to leave, as thorough of a message as needed, from Dr. Skalski's office.

__ Home Telephone ________________________________________

  __ OK to leave a message on machine with detailed message
  __ OK to leave message with call-back number only
  __OK to leave message with family member (Who?) ________________________________________________

__ Work Telephone ________________________________________

  __ OK to leave a message on machine with detailed message
  __ OK to leave message with call-back number only
  __ OK to leave message with co-worker (Who?) ___________________________________________________

__ Cell Telephone __________________________________________

  __ OK to leave a message on voicemail with detailed messege
  __ OK to leave message with call-back number only

I authorize Dr. Skalski to release any information including diagnosis and the records to any treatment or examination rendered to me or my child during the period of such medical care to third party payers and/or health practitioners.

**Signature of Patient or Legal Guardian ______________________________________ Date _______________**

**(Patients 18 and over must complete this form)**

*Witness Signature _________________________ Date __________*