HIPAA Consent

Jose Ignacio Lopez, MD.,PA

I understand that as part of my healthcare, Jose Ignacio Lopez, MD.,PA. , originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future treatment. I understand that this information serves as:

- A Basis for planning my care and treatment;
- A means for communication among health professionals who contribute to my care, such as referrals;
- A source of information for applying my diagnosis and treatment information to my bill;
- A means by which a third-party payer can verify that services billed were actually rendered;
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

I understand that as part of treatment, payment or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law. I fully understand and ☐ accept ☐ decline this consent.

Notice of Privacy Practices
I acknowledge that I have been informed of Jose Ignacio Lopez, MD.,PA.'s Notice of Privacy Practices that provides a description of our practice's uses and disclosures of Protected Health Information. I understand that I have the right to review the Notice of Privacy Practices and receive a copy before signing this statement. I understand that Jose Ignacio Lopez, MD.,PA. has the right to change its Notice of Privacy Practices that will be effective for health information Jose Ignacio Lopez, MD.,PA. already has about me, as well as any they receive in the future. Jose Ignacio Lopez, MD.,PA. has posted a current copy of the Notice of Privacy Practices in our lobby for review. I understand that I may obtain a copy of the current Notice in effect upon request. I have read all of the above and understand/agree to all the provisions therein regarding responsibility for payment, permission for treatment and Notice of Privacy Practices.

Requesting Medical Records From Our Office
Our office requires patients and their representatives to sign an Authorization Form before release of medical records.

Messages From Our Office and/or Appointment Reminders

	Yes	No	Phone #/Email to Use
May we leave a message at your home using doctor's/practice name?	☐	☐	
May we leave a message at your work using doctor's/practice name?	☐	☐	
May we text you appointment reminders and other messages?	☐	☐	
May we email you appointment reminders and other messages?	☐	☐	

Please list all family members or other person(s), if any, whom we may disclose your protected health information, including treatment and payment information. These persons will have full access to your protected health information.

NAME	PHONE NUMBER

Please print the address where you would like your billing statements and/or correspondence from our office sent.

I have read, filled out and agree to all of the above.

Patient/Guardian Signature:	Patient Name if Different:		
Printed Name:	Date:		
If other than the patient is signing, are you the legal guardian, custodian or have Power of Attorney for this patient for payment, treatment or healthcare operations?		Yes ☐	No ☐