SoCO Primary Care Clinic

Medical Information Release Form

(HIPAA Release Form)

I understand that I have certain rights to privacy regarding my health information. These rights are given to me under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I understand that by signing this consent, I authorize **SoCO Primary Care Clinic** to use and disclose my protected health information (PHI) to carry out the follow:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of SoCO Primary Care Clinic

I have also been informed of and given the right to review and secure a copy of the SoCO Primary Care Clinic Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my PHI and rights under HIPAA. I understand that SoCO Primary Care Clinic reserves the right to change the terms of this notice at any time and that I may contact SoCO Primary Care Clinic at any time to obtain the most current copy of this notice. I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the revocation date is not affected.

Name (Print):_____ Signature:_____ Date:_____

I wish to be contacted in the following manner: **BE SURE TO FILL IN CONTACT PHONE NUMBERS AND CHECK WHETHER WE CAN LEAVE A DETAILED MESSAGE OR JUST A MESSAGE TO CALL THE OFFICE BACK**. If you do not accept blocked calls, any return may be delayed, unless you remove this feature from your phone.

O **Home Telephone:**_____

O Can leave a detailed message

O Leave a message with a call back number only

O **Alternate Phone:**_____

O Can leave a detailed message

O Leave a message with a call back number only

O **Work Telephone:**_____

O Can leave a detailed message

O Leave a message with a call back number only

O **Written Communication**

O Can send letter with detailed information

O Only send a letter stating to contact the office

PLEASE INDICATE WHO WE CAN SPEAK TO REGARDING YOUR MEDICAL INFORMATION (check all that apply)

O Patient only

O Significant Other Name:_____ Phone:_____

O Parent(s) Name:_____ Phone:_____

O Other Name:_____ Phone:_____

I ACKNOWLEDGE THAT THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT UNTIL OTHERWISE STATED BY ME IN WRITING.

Name (Print):_____ Signature:_____ Date:_____