Comprehensive OB/GYN HIPAA and General Consents

Patient Name _____ **Date of Birth** _____ **Today's Date** _____

Notice of Privacy Practices Acknowledgement

_____ I acknowledge I have received or have been given an opportunity to receive **Comprehensive OB/GYN's** Notice of Privacy Practices which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the **Comprehensive OB/GYN's** Notice of Privacy Practices.

Release of Information

_____ I permit the practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment or healthcare operations.

- Healthcare information regarding a prior admission(s) at other facilities may be made available to subsequent admitting facilities to coordinate patient care for case management purposes. Healthcare information may be released to any person or entity liable for payment on the patient's behalf in order to verify coverage or payment questions or for any other purpose related benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers and /or other healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes and such other purposes as may be permitted by law. I understand this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological, psychiatric, intellectual disability and chemical dependency conditions as well as genetic information and/or infectious diseases including, but not limited to, blood borne diseases, such as Hepatitis, Human Immunodeficiency Virus (HIV) and Acquired Deficiency Syndrome (AIDS).

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below. I understand this does not authorize release of my medical records. A separate authorization to release medical records is needed for each and every facility or person I request a copy be sent to via US Postal Service.

Name _____ **Relationship** _____

Name _____ **Relationship** _____

Name _____ **Relationship** _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations

_____ I consent to photographs, videotapes, digital or audio recordings and/or images of me being recorded for security purposes and/or the hospital's healthcare operations purposes (e.g., quality improvement activities). I understand the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand these image and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside of the practice without a specific written authorization from me or my legal representative unless otherwise required by law.

Patient/Patient Representative Signature _____ **Date** _____