The Internal Medicine Clinic, LLC.

Patient HIPAA Acknowledgement and Consent Form

Patient Name: ____

Date of Birth: ____________________ Patient#: ___________________ Doctor ____________________

______ (Patient initials) Notice of Privacy Practices. I acknowledge that I have received the IMC'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 that 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 purpose described in the Practice's Notice of Privacy Practices.

______ (Patient initials) Consent to Treat. I authorize IMC and staff to provide medical services to me and authorize the disclosure of protected health information for purposes of payment, health care operations and treatment. This includes communication with my physicians, pharmacist, and hospitals by letter, phone, or fax. I understand that I have the right to request treatment, payment, and healthcare operations, and the IMC may refuse this request. I understand that unless the IMC has taken action in reliance on such consent that I may revoke this consent, by giving written notice.

______ (Patient initials) MEDICARE POLICY. I request that payment of authorize Medicare benefits be made on my behalf to IMC four e-services items furnished to me by the physicians of IMC. I'll further requested authorized Medigap benefits being made on my behalf to IMC. Authorize any folder of medical information about me to be released to CMS and it's agents and/or my Medigap carrier, or benefits payable related services. I understand this is a lifetime Medicare benefit assignment, and that I may cancel this assignment at any time in writing.

______ (Patient initials) 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:

Name	Relationship	Contact Number
1		
2		
3		

Authorization to Leave Message
I authorize IMC and staff to leave messages regarding my medical conditions, such as lab reports, appointments, reminders, other test results, information about medications, and other general health information when necessary, on my home or cell answering machine.

______ (Patient initials)   ( ) Agree   ( ) Disagree

Eprescribe all my prescriptions to: ____
Pharmacy Name/Location

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

______ (Patient initials) I wish to designate the following family member / friend to pick up an order or prescription on my behalf:

Name: ____ Date: ________________________