Richmond Family Medicine Associates

Comprehensive Care for Your Entire Family

312 Jason Drive, Suite 9
Richmond, KY 40475
Phone (859) 575-4075
Fax (859) 575-4126
www.richmondfamilymedicineky.com

DR. KASEY EIDSON, MD, PHD

HIPAA PRIVACY POLICY PATIENT CONSENT FORM

Full Name ____

Date of Birth __________________________ Social Security Number ________-_______-__________

Voice Messages for General Healthcare Information

If unable to reach me, I give permission to the physicians and their staff at Richmond Family Medicine Associates to (Choose **ONE** of the following):

________ Leave detailed voice messages at the following phone number(s) for appointment reminders, general office reminders, and point of care notifications regarding my health information including results and diagnostic information, payments of balance, care plans, and referrals, when I am not available at the following number(s) Cell _______________________ Home ______________________

_________ Leave a message asking me to return your call

_________ Other ____

Sharing of Your Health Information and Results

_________ I give my permission to the physicians and their staff at Richmond Family Medicine Associates to share my health information including results, diagnoses, and appointment information with the following person(s):

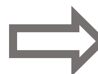
Name	Relation	Phone Number
______________________________	_________________	_________________________
______________________________	_________________	_________________________
______________________________	_________________	_________________________
______________________________	_________________	_________________________

_________ I do not wish to have my health information shared with anyone

Patient Signature ____ **Date** _______________

Parent or Guardian Signature __________________________________ Date _______________

Witness Signature ____ Date _______________



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I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- -Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- -Obtaining payment from third party payers (i.e. my insurance company)
- -The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name ____

Parent or Guardian ____

Signature ____ **Date** __________________