Notice of Privacy Practices & Permission of Patient Contact

My Signature below indicates that I have received and reviewed Edison Medical Associates notice of privacy practices

PERMISSION OF PATIENT CONTACT(Effective April 2003 under Federal law)

Please provide at least two numbers where our staff might contact you

Home Phone: _____Work Phone: _____ Cell Phone: _____

In the event that we cannot contact you at either, may we leave a message on any of these numbers?

Home Phone: __ **Yes** __ **no** Work Phone: __ **Yes** __ **no** Cell Phone: __ **Yes** ___ **no**

Please provide the names of any persons that you would permit us to discuss your medical status

Note: due to privacy laws we are not permitted to discuss health information with anyone not listed below

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patients Name: _____

Patient Signature: _____ Date: _____

Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal care information is protected for privacy. The Privacy Rule was also created for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health information and relevant information about treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak to our Office Manager.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you reviewed our privacy notice

Print Name: _____Signature: _____Date: _____

Compliance Assurance Notification For our Patients

To our Valued Patients

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that our employees, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding HIPAA with particular emphasis on the "privacy rule". We strive to achieve the highest standards of ethics and integrity in performing services for our patients

It is our policy to properly determine appropriate use of PHI in accordance with government rules, laws and regulations. If you have questions or concerns, please reach out to us and we will remedy the situation promptly