Women's Health
OF THE EMERALD COAST

HIPPA Information and Consent

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy.
A Notice of Privacy Practices should be available to you in the office. The notice provides information about how we may use and disclose protected health information about you in order to carry out treatment, payment, and healthcare operations, and for other purposes permitted or required by law. The notice also contains information about your rights under the law.

Additional information is available from the U.S. Department of Health and Human Services.

By signing below you understand and agree to the terms of our notice of privacy practices which include:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- Authorization is required for certain disclosures of your Protected Health Information.
- You have the right to opt out of fundraising communications.
- You have the right to restrict disclosures of your Protected Health Information under certain circumstances.
- You have the right to be notified of a breach of unsecured Protected Health Information.

By Signing below you understand and agree that:

- The practice has a Notice of Privacy Practices that you have had the opportunity to review.
- The practice reserves the right to change the Notice of Privacy Practices and if we change our notice you may obtain a revised copy by contacting our office.
- You may revoke this consent in writing at any time and all future disclosures will cease.
- The practice may condition treatment upon the execution of this consent.

YOU WILL NEED TO SIGN THIS PORTION IN THE OFFICE ON THE IPAD

Signature

Women's Health
OF THE EMERALD COAST

This consent form allows Women's Health of the Emerald Coast to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry out treatment, payment or health care operations.
Women's Health of the Emerald Coast has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.
I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by contacting the Privacy Officer at Women's Health of the Emerald Coast.

_____ I hereby authorize that Women's Health of the Emerald Coast may leave messages on my voicemail to confirm Initial appointments, and/or may speak with other members of my household and leave messages with them regarding my appointments. I also authorize Women's Health of the Emerald Coast to:
Provide appointment conformation by phone, mobile text and email. These are only an automated reminder of your appointment. No Clinical information will be release.
_____ I hereby authorize that Women's Health of the Emerald Coast may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the clinic while I meet with my healthcare provider(s).

_____ I hereby authorize that Women's Health of the Emerald Coast may disclose my personal health information to the person who I have listed as my emergency contact.

_____ I hereby authorize that Women's Health of the Emerald Coast may disclose my personal health information to the Initial following person(s):

Name	Telephone Number	Relationship to Patient

I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Women's Health of the Emerald Coast services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Women's Health of the Emerald Coast may refuse service if I revoke this consent.
I understand that I have the right to request – now and in the future – how protected health information is used or disclosed to carryout treatment, payment and health care operations, and must be provided by me in writing. I understand that while Women's Health of the Emerald Coast is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement.

I understand that Women's Health of the Emerald Coast may refuse me services if I refuse to sign this consent.
By my signature below, I affirm the above information.

Signature of Patient _____ **Date**_____

Signature of Parent (if minor)
Authorized Representative_____ **Date**_____

Witness:_____