REX OBGYN

HEALTH INSURANCE PORTBILITY AND ACCOUNTABILITY ACT (HIPAA)

PATIENT CONSENT FORM

Dear Patient,

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires us to provide you with our notice of privacy practices. The privacy notice includes our policies on reviewing, amending and/or copying your protected health information (PHI).

Our goal is to protect your PHI and we encourage you to read our notice of privacy practices.

Please review the following before signing:

1. I understand that my individual identifiable protected health information (PHI) may be used and disclosed to carry out treatment, payment or healthcare oversight activities.
2. I understand that I may request that Rex OBGYN restrict how my individual identifiable PHI is used or disclosed to carry out treatment, payment or healthcare oversight activities. Rex OBGYN is not required to agree to requested restrictions, but if Rex OBGYN agrees to a requested restriction, the restriction will be binding.
3. I understand that I may revoke the consent at any time by notifying Rex OBGYN in writing, except to the extent Rex OBGYN has taken action in reliance on the contract.
4. I may restrict the use and disclosure of my PHI related to psychiatric care, substance abuse disorder, and HIV/AIDS, except for the purpose of treatment, payment or healthcare operations.
5. I have been provided or offered a copy of Rex OBGYN's HIPAA statement and privacy practice notice.

I give permission for Rex OBGYN to disclose to the below mentioned individuals any and all of my protected health information.

Name: Relationship: Contact Information:

_____

_____

Patient Signature Date of Birth Today's Date

_____

Please Print name

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