North Georgia Endocrinology

1. PATIENT CONSENT FORM

I understand I have certain rights to privacy regarding my protected health information. These rights are given to me under the 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 the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third-party payers (e.g., insurance companies)
- The day-to-day healthcare operations 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 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. I understand I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations. However, you are not required to agree to these requested restrictions. However, if you agree, you are bound to comply with this restriction. I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred before the date I revoke this consent is not affected.

2. PATIENT AUTHORIZATION FORM:

This authorization sets forth your right to use or disclose my protected health information as specified below for the purposes and parties as designated below.

DESCRIPTION OF SPECIFIC INFORMATION AUTHORIZED:
-Any information needed to process insurance claim forms.
DESCRIPTION OF THE SPECIFIC PURPOSES FOR USE AND DISCLOSURE: Billing purposes
PARTIES REQUESTING INFORMATION AND AUTHORIZED TO USE AND DISCLOSE THE INFORMATION:
-Authorized representative of my insurance carrier
PARTIES TO WHOM INFORMATION MAY BE DISCLOSED:
-Authorized representative of my insurance carrier

<u>I reserve the right to:</u>

- Revoke this authorization in writing by submitting it to the attention of your Privacy Officer
- Inspect or copy the protected health information to be used or disclosed
- Refuse to sign this authorization knowing that you will condition treatment or payment on my providing this authorization (except for research-related treatment)

I understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.
Under certain circumstances, we may receive compensation from a third party requesting your medical records.

Print Patient Name:_____Date:_____
Signature: _____DOB:_____