# HIPAA Patient Consent

I understand that 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 ***Horizons OB-GYN & Aesthetics (Dr. Manny Herrera, Katie Herrera, APRN)*** to use and disclose my protected health information to carry out:

- Treatment (Including direct and 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 operations of our practice.

I have also been informed of and given the right to review and secure a copy of our 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 the office reserves the right to change the terms of this notice from time to time and that patients may contact us 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 these requested restrictions. However, if ***Horizons OB-GYN & Aesthetics (Dr. Manny Herrera, Katie Herrera, APRN)*** does agree in writing, then he or she is 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 prior to the date I revoke this consent is not affected.

May we phone, email, or send a text to you to confirm appointments? YES____ NO____

May we leave a message on your answering machine at home or on your cell phone with lab results?
YES___NO___

Is there another individual you would like to release medical records, financial information and treatment plans to?

Name:_____ Relationship to Patient:_____Phone #_____

Name:_____ Relationship to Patient:_____Phone #_____

If you want certain information excluded from being released please list below:

HIV/STD results_____ Other:_____

Signed this date:_____

Patient Name Printed:_____

Signature of Patient/Guardian:_____