NorthEast Wisconsin Community Clinic

Patient HIPAA Acknowledgment and Consent Form

Patient Name_____ Date of Birth_____/_____/_____

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHO?

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number
1.		
2.		
3.		

Patient may revoke/modify this specific authorization and that revocation/modification must be in writing.

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_____ **(Patient initials)** Notice of Privacy Practices. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ **(Patient initials)** Release of Information. I hereby permit practice and the physicians or other health professionals involved in the outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, laboratory reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

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Consent to Care:

I understand that by signing this agreement, I consent to all general outpatient medical care, dental care and or routine outpatient services, including evaluation, therapies, nursing care and diagnostic testing provided under the general or specific instruction of my physician(s) and other health care providers. I understand that my physician(s) or other health care providers may be accompanied and/or assisted by students, interns, and residents during my care. I consent to the presence and/or participation in my treatment by these persons while under the direction or supervision of my physician(s) or other authorized health care providers.

Patient Signature: _____ Date: _____

Patient Name (Printed): _____ DOB: _____

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at the email or text address from the practice.

_____ **(Patient initials)** I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is _____.

The email that I authorize to receive email messages for appointment reminders, feedback, and general health reminders/information is _____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via email and/or text.
____ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.*
____ *I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.*
NOTE: This revocation only applies to communications from this practice.
Patient Name: _____
Patient/Patient Representative Signature: _____
Date: _____ Time: _____

Prescription Order Pick-Up

There may be times when you need a friend or family member to pick up a prescription order (script) from your physician's office. For us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

_____ **(Patient initials)** I wish to designate the following family member/friend to pick up and order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

_____ **(Patient initials)** I do not want to designate anyone to pick up my prescription order.