Lake Howell Health Center
Consent/HIPPA Form

Financial Policy/Authorization to release **inform to insurance company**

I, Undersigned, certify that I (or my dependent) has insurance coverage as listed above and assign directly to LHHC understand that I am financially responsible for all charges whether or not paid by insurance. I remain responsible for payment of copayments, deductibles, non-covered services, and any other charges not paid by insurance within 30 days. I hereby authorize Lake Howell Health Center (LHHC) to release all information necessary to secure payment of benefits. I authorize the use of this signature for all insurance claims.

Signature X _____ Date: _____

Are you the Guarantor? Yes___ No___ If not please see the receptionist.

Consent for Treatment & Release information to pharmacy/consulting physician

I acknowledge recognition of the fact that the evaluation and treatment received, may be discussed with a designated pharmacy/consulting physician. I also give LHHC permission to discuss RX history, advised or deemed necessary, to be at the judgment of the physician.

Signature X_____ Date: _____

Acknowledgement of receipt of privacy notice (HIPPA)
Health Insurance Portability and Accountability Act

By signing this form, you acknowledge that LHHC has offered or given to you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must attempt to have you sign this form on your first date of service with us after April 2003.This includes the situation where your first date of service occurred electronically. If your first date of service with us was an emergency, we must attempt to give you this notice and get your signature acknowledging receipt of this notice as soon as possible after the emergency.

D I have received a copy of the Privacy Notice of LHHC

D LHHC has offered me a copy of the Privacy Notice which I have declined and has given me the chance to discuss my concerns and questions about the privacy of my health information.

Signature X_____ Date: _____

Additional Person(s) Authorized to make the use **or disclosure of my PHI**

We at LHHC value and do everything in our power to protect your privacy. Your medical information will not be given to any individual (including spouses, parents, children, or any significant other with out written consent), if you want anyone other than your referring physician to have access to your medical information please list their name(s), and relationship(s) below. (Note: Uses and disclosures may be permitted without prior consent in an emergency.)

Name_____ Relationship _____

Name_____ Relationship _____

Signature X _____ Date: _____

Witness Signature

The Staff of LHHC complete this section of Acknowledgement Form if not signed by the Patient:

1. Does the Patient have a copy of the Privacy Notice? Y or N
2. Please explain why the patient was unable to sign an acknowledgment form and our efforts in trying to obtain the Patient signature: _____ ----------

Employee Signature: _____ . _____ Date ----------