Aegis Medical Center

Internal Medicine

HIPPA Form

I, _____ understand that as part of my healthcare, Aegis Medical Center, originates and maintains electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for further care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communications among the many health professional that contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand I have the right to request a copy of Aegis Medical Center Privacy Policies that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right of review the notice prior to signing this consent
- The right to object to use of my health information for directory purposes
- The right of request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand that Aegis Medical Center is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code Federal regulations.

I further understand that Aegis Medical Center reserves the right to change their notice and practices prior to implementation, in accordance with section 164.520 of the code of Federal Regulations. Should Aegis Medical Center, change their notice, they will send a copy of any revised notice to the address I have provided (whether US Mail or if I agreed, E-mail)

I authorize Aegis Medical Center to disclose my health information to:

Name _____ Relationship to Patient _____
Name _____ Relationship to Patient _____

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosures via fax.

I full understand and ☐ accept or ☐ Decline the terms of this consent

Patient Signature _____ Date _____

Witness Signature _____ Date _____

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