

Stefanie McCain, M.D.
Hippa Form

Dear Patient:

Physicians have always protected the confidentiality of our patient's health information by securing medical records away from open access and refusing to reveal information. Additionally, State and Federal laws set security standards to ensure the confidentiality of this sensitive information.

The federal government published regulations designed to protect the privacy of your health information. The "Privacy Rule" protects health information that is maintained by hospitals, health care providers and health plans. Physicians, as of April 13, 2003, must comply with the federal government's regulations privacy rule's standards for protecting the confidentiality of your health information.

This new regulation protects virtually all patients regardless of where they live or where they receive their health care. Every time you see a physician, are admitted to a hospital, fill a prescription, or send a claim your health care provider will need to comply with the privacy rules. All health information including paper, oral, or electronic are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions. We also take precautions in our office to safeguard your health information, such as training our employees and employing computer security measures.

In the reception room, we have placed copies of our NOTICE OF PRIVACY PRACTICES. This notice contains very important information about how you can exercise your rights with regard to your protected health information. We request that you take the time to review the privacy practices of the office before you see the medical providers.

You may request, from the receptionist, a copy of the NOTICE OF PRIVACY PRACTICES to take with you for further review. Federal regulations require that we document that the patient has been advised of our privacy practices and offered a copy of the notice. Additionally, we must receive documentation for both the notice and consent for communication. If you have any questions regarding our privacy practices you may schedule a meeting with the privacy officer for further details and review.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's NOTICE OF PRIVACY PRACTICES, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the document. Furthermore, by my specific initials, I authorize my physician and his/her staff, to contact me by the designated means noted below.

May we call and/or leave a voicemail at: _____ HOME PHONE _____ OFFICE PHONE _____ CELL PHONE

May we text cell phone: YES OR NO (standard text messaging rates apply from your carrier) _____ FAX

I authorize my physician and his/her staff to communicate information regarding my appointment, medical results, billing issues to:

_____ Spouse _____ Other _____

_____ Other _____ Other _____

This Authorization shall remain in force until revoked in writing to attention of Privacy Officer.

Signature of Patient or Personal Representative

Printed Name

Date