

BAY WALK-IN CLINIC, INC.
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Name _____

Social Security Number _____ Phone _____

Address _____

Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

The Health Insurance Portability & Accountability Act of 1996 (S160.103) – Defines individual health information as information, including demographic information collected from an individual and:

- (1) Created or received by a health care provider, health plan, employer, or healthcare clearing house; and
- (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for provision of health care to an individual.
- (3) The information therefore identifies an individual or provides a reasonable basis to believe the information can be used to identify the individual.

Permitted disclosure (S164.502) and uses by a health care provider include:

- (1) For treatment, payment or health care operations as permitted under this law
- (2) Uses or disclosure to a personal representative assigned by the patient
- (3) Disclosure to the parents or persons acting in loco parentis to an unemancipated minor
- (4) For case management or care coordination for the individual or to direct or recommend alternative treatments, therapies, health care providers, health care settings.

Notice of Privacy Practices: Our Notice of Privacy Practices is posted. Detailed information will be provided to you upon your request.

Right to Revoke: You will have the right to revoke this Consent at any time by submitting written notice of your revocation to our Privacy Officer:

Pam Nelson, Privacy Officer
2306 Highway 77
Panama City, FL 32405

Phone (850)763-9744
Fax (850)785-2020

Please understand that HIPAA laws prevent us from processing claims for TPO (Treatment, Payment, Healthcare Operations) without an appropriate disclosure form. It will be necessary for you to provide cash or credit card for payment of services.

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. This includes _____, (if here for a company please print company name).

Signature _____ Date _____

Expiration Date of this consent form: _____ (one (1) year from date of signature)

Witness _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name _____

Relationship to Patient _____

Address _____ Phone _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

INCLUDE COMPLETED CONSENT IN THE PATIENT'S CHART. CHART # _____