HIPAA Compliance Patient Consent Form

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have rights to privacy regarding my protected health information (PHI). I understand that under HIPAA this PHI may be used for coordinating, planning, and conducting treatment with healthcare providers directly or indirectly involved with my treatment, obtaining any potential payment with third party payers, and conducting normal healthcare operations such as quality assessments/evaluations.

The Mint Health Clinics Lone Tree (MHCLT) "*Notice of Privacy Policies*" provides details regarding the uses and disclosures of my PHI and my rights under HIPAA. I understand that I have the right to a copy of the notice, and that by my signature below I ascertain that I have reviewed, or have had the chance to review, the notice prior to signing this consent.

I understand that terms of the "*Notice of Privacy Policies*" may change, and that I have the right to request the most current copy of the notice. I have the right to revoke this consent in writing, signed by me. However, such a revocation will not be retroactive.

Release of Information

[ ] I grant permission for my PHI to be disclosed for the purposes of communicating results, findings, and care discussions to the family members and/or others listed below:

Name	Contact Information	Relationship

[ ] Information is not to be released to anyone

Messages

Please specify how MHCLT may contact you regarding your health information.

Phone	**Email**
[ ] Home (_____)-_____-_____	[ ] Home _____
[ ] Work (_____)-_____-_____	[ ] Work _____
[ ] Cell (_____)-_____-_____	[ ] Other _____
[ ] Other (_____)-_____-_____	

If unable to reach me:

[ ] Leave a detailed message [ ] Leave me a message asking me to return your call

[ ] Other: _____

_____
Printed Name

_____
Signature

_____
Relationship to Member if signed by Member's representative