HIPAA DISCLOSURE/ PATIENT CONSENT FORM

Ashok P.C. wants to protect the privacy of patients health information (PHI), and comply with any regulations regarding the use and disclosure of patient health information. In accordance with this, Ashok P.C. is permitted to use and disclose my PHI for treatment, payment and health care operational purposes. Ashok P.C. is also permitted to disclose my PHI in compliance with guidelines outlined by law and when required to do so by various government agencies. I have the right to request restrictions on certain uses and disclosures of my PHI and to request portions of my PHI be amended as well as the right to inspect and receive a copy of my PHI.

☐ I want a copy of Privacy Health information.
☐ I do not want a copy of Privacy Health information as I am aware of the policy.

Further, I agree to the following:

- I will come for my follow-up as advised.
- I will keep all follow-up appointments to discuss my test result(s).
- I will call 24 hours in advance to reschedule my appointment

I authorize Dr. Patel and his staff to contact me electronically via text message or an email for all my dealings and interactions with Dr. Patel.

I consent and authorize Dr. Patel and his staff send me e-statements via text message or email. I understand and agree it is my responsibility to make full payment for Dr. Patel's services.

Email Address

Nurse's Signature

Please note that email may not provide a secure means of communication. There is some risk that any protected health information contained in email may be disclosed to, or intercepted by, unauthorized third parties. Use of more secure communications, such as mail, phone or fax is always an alternative. I accept the risks involved with insecure email communication of my protected health information.

_____ Date _____
Patient Name Signature

AUTHORIZATION FOR SPOUSE OR CAREGIVER CONSENT

Access to your PHI or discussion thereof with those individuals such as caregivers, family members, relatives or close personal friends, etc., can only be granted with your written permission. In accordance with this, please list below those individuals with whom your PIF can be shared.

I hereby authorize the following individuals to have access to my private health information. I further understand that if this list of spouse/or caregiver authorization should change, I am responsible to inform the office of Ashok Patel, M.D. and complete a new consent form.

1. _____

2. _____

☐ Not applicable

_____ _____
Patient Signature Date

Typing your name is equivalent to your handwritten signature
By typing my signature and sending it via the Internet, I acknowledge that I have read and understand all information provided in this form; that I intend Ashok PC to rely upon it; that I intend to be bound thereby; and that I understand and agree that my electronic signature is the equivalent of a manual written signature.

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