HealthCareClinics
the caring professionals

## Notice of Patient Privacy/Patient Consent Form

I understand that as part of my healthcare, the physicians of HealthCareClinics originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

HealthCareClinics *Notice of Privacy Practices* provides specific information and complete description of how my personal information may be used and disclosed. I understand that a copy of the *Notice of Privacy Practices* is available at the front desk and understand that I have the right to review the notice prior to signing this consent. I understand that HealthCareClinics reserves the right to change the *Notice of Privacy Practices.* Prior to implementation of the revised *Notice of Privacy Practices* , the revised *Notice* will be mailed to me if I provide my address below. I understand I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or healthcare operations and that HealthCareClinics is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that HealthCareClinics has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

NOTE: HealthCareClinics must obtain your written authorization to use your Private Health Information for any purpose other than treatment or billing. If you want HealthCareClinics to have access to disclose your Private Health Information to your spouse or any other person during your treatment, please sign below.

I agree to allow HealthCareClinics to disclose my Private Health Information (including date/time of appointments) to:

___ Spouse _____ Tel (____) _____ - _____
(print name)

___ Family Member(s) _____ Tel (____) _____ - _____
(print name)

___ Other (i.e. friend, physician etc.) _____ Tel (____) _____ - _____
(print name)

___ Myself only, no other family member

This does not serve as an Authorization to Release Medical Records

I further understand that any and all records, whether written, oral, or in electronic format are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. I understand that I have access to or have reviewed HealthCareClinics *Notice of Privacy Practices* for the following medical practice:

HealthCareClinics
5315 Ross Avenue
Dallas, Texas 75206
Tel: (214) 826-2151
Privacy Official: Laura Miller – Office Manager

**A copy of this agreement may be used with the same effectiveness as an original.**

Print Name of Patient/Legal Representative _____ Date ___/___/___

Signature of Patient/Legal Representative _____ Patient Date of Birth ___/___/___