Rheumatology Center of Princeton
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PATIENT CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal health information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. Organizations that do not require patient consent in order to share Protected Health Information (PHI) are called “Covered Entities.” For your information, automobile insurance carriers and Workman’s Comp are not considered Covered Entities by HIPAA and as such we as a practice are not required to share PHI with those organizations.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your PHI. If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have a right to review our privacy notice, to request restrictions, and to revoke consent in writing after you have reviewed our privacy notice.

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Patient Name Signature Date

I give authorization for the following people to get information by telephone or pick up records that I have requested regarding my medical care:

_____

Name Relationship

_____

Name Relationship

_____

Patient Name Signature Date