Endocrinology of Central Pennsylvania, LLC

2020 Good Hope Rd, Suite 100, 1st Floor, Enola PA 17025
Phone: 717-728-ENDO (3636) Fax: 717-728-3640

HIPAA – CONSENT AND DISCLOSURE FORM

Effective Date: January 1, 2015

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

WHO WILL FOLLOW THIS NOTICE

This notice describes Endocrinology of Central PA, LLC hereafter referred to as ENDOCPA practice and that of:

- Any health care professional authorized to enter information into your ENDOCPA chart.
- Any member of a volunteer group we allow to help you while you are a patient with ENDOCPA.
- All staff members of ENDOCPA.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that your medical information is personal and we are committed to protecting that information. We create a record of the care you receive at ENDOCPA. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the practice, whether made by practice personnel or your primary care physician.

This notice will tell you about the ways we may use and disclose your medical information as well as explain what your rights and obligations are regarding the use and disclosure of the informa-tion. Law to requires us to:

- Make sure that medical information that identifies you is kept private.
- It provides you with a notice of our legal duties and privacy practices with respect to medical information about you.
- We will follow the terms of the notice that is currently in effect.

1. Providing appropriate security for our patient records.
2. Protecting the privacy of our patient's medical information.
3. Providing our patients with proper access to their medical records.
4. Appropriately maintaining our patient information and billing process in compliance with national HIPPA standards.

If you ever have any questions or concerns about your services or charges, we encourage you to call and ask for our Officer Manager.

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PATIENT CONSENT FORM

The Department of Health and Human Services has established "Privacy Rule" to help insure that personal 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 patients, 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 purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent

You may refuse to consent to the use of discloser 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 Personal Health Information (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 Office Manager. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

I authorize the office of Endocrinology of Central PA, LLC to continue making confirmation calls, and leaving messages on my answering machine to remind me of my upcoming appointments.

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_____

Date

Name of Patient

_____

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Signature of Patient / Guardian