

Reyes Family Medicine

Notice of Privacy Practices Acknowledgment Form HIPAA

I acknowledge that I have received a copy of the **Reyes Family Medicine** Notice of Privacy Practices and have had an opportunity to review it. I have also been given an opportunity to request restriction on the use and disclosure of my protected health information, as well as to request confidential treatment of communications relating to my health information.

1. _____
Patient acknowledgement (Signature)

Date

Consent for Purposes of Treatment, Payment and Health Care Operations

I understand that, as a condition to my receiving treatment from **Reyes Family Medicine, Reyes Family Medicine** may use or disclose my personally identified health information for treatment to obtain payment for the treatment provided and as otherwise necessary for the operations of **Reyes Family Medicine**. These uses and disclosures are more fully explained in the Notice of Privacy Practices that has been provided to and reviewed by me.

While I am here, I permit the employees, the doctor and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand the attending physician will explain to me the nature of my condition, his or her recommended treatment and any associated risk involved. I also understand that he or she will explain to me other ways this condition could be treated. I further understand that this care may include diagnostic testing, examinations, and medical and/or surgical treatment, and that no guarantees have been made to me about the outcome of this care.

"Personally identifiable health information" refers to health and demographic information collected about me by my physician (or other health care provider, public health authority, health plan, employer, life insurer, school or university, or health care clearinghouse) that relates to my past, present or future physical or mental health or condition or payment for provision of health care. The information identifies me, or there is a reasonable basis to believe that the information may identify me.

I understand that privacy practices described in the Notice of Privacy Practices may change over time and that I have a right to obtain any revised Privacy Notice by contacting **Reyes Family Medicine** to make such a request. I may receive a revised Notice of Privacy Practices by calling the office and requesting a revised copy by mail or by asking for one at my next visit.

I also understand that I have the right to request **Reyes Family Medicine** to restrict how my health information is used or disclosed. **Reyes Family Medicine** does not have to agree to my request for the restriction, but if **Reyes Family Medicine** does agree, **Reyes Family Medicine** is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdraw this consent, in writing, at any time. My revocation/withdrawal will be effective except to the extent that **Reyes Family Medicine** has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent.

2. _____ Signature
Date

Medicare lifetime consent & Medicaid: I certify that the information given by me in applying under Title XVII of the Social Security Act is correct, and I authorize any holder of medical or other information about me to release it to the Social Security Administration or its intermediaries or carriers as needed for this or a related Medicare claim. I assign the benefits payable for the physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

3. _____
Signature Date