PATIENT HIPAA ACKNOWLEDGEMENT/DISCLOSURE

HENDRICK PROVIDER NETWORK

I understand Congress passed a law entitled the Health Insurance Portability and Accountability Act ("HIPAA") that limits disclosure of my protected health information ("PHI"). This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the person(s) designated below in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends.

Therefore, pursuant to 45 CFR 164.501(a)(1)(iv) Hendrick Provider Network, a covered entity (being a healthcare provider as defined by HIPAA), is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR §164.508.

I, _____, hereby authorize Hendrick Provider Network to disclose the following information:
(PRINT NAME)

All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of healthcare providers, whether past, present or future, and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person(s) or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give full authorization to ANY protected medical information to the person(s) named in this authorization.

By signing this authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the person(s) whose name(s) are written below, and the information, once disclosed, will no longer be protected by the rules created in HIPAA.

This authorization shall remain in effect until my WRITTEN MODIFICATION and/or REVOCATION is received by Hendrick Provider Network.

PERSON'S AUTHORIZED TO RECEIVED MY PROTECTED HEALTH INFORMATION (PHI)					
1st Contact:	Last Name:	First Name:		Relationship:	
Home Phone:	Cell Phone:	Work Phone:		Other Phone:	Gender: ❑ M ❑ F
2nd Contact:	Last Name:	First Name:		Relationship:	
Home Phone:	Cell Phone:	Work Phone:		Other Phone:	Gender: ❑ M ❑ F
3rd Contact:	Last Name:	First Name:		Relationship:	
Home Phone:	Cell Phone:	Work Phone:		Other Phone:	Gender: ❑ M ❑ F

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES		
Your name and signature below indicate that you received a copy of Hendrick's Notice of Privacy Practices, effective September 23, 2013, on the date indicated below. If you have any questions regarding the information set forth in this Notice of Privacy Practices, please do not hesitate to contact the Privacy Officer at (325) 670-7763.		
Printed name of Patient:	Signature of Patient:	Date Signed:
Signature of Patient's Representative:	Relationship to Patient:	Reason Patient Unable to Sign: