Primary Care Associates

HIPAA FORM

THIS NOTICE DESCRIBES HOW MEDICAL/BILLING INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY. FORM EXPIRES ONE YEAR FROM DATE.

Under the Health Insurance Portability and Accountability Act of 1996 (**HIPPA**) limits with whom we can discuss your health/billing information with. If there is a person or persons with whom you would like us to be able to discuss you or your dependent's health/billing information, you ***must*** designate them below.

This form must be signed and dated in order for Primary Care Associates to disclose or discuss any medical/billing information on behalf of the patient.

Patient Name:	Date of Birth:
Patient Address:	

I authorize Primary Care Associates to discuss or release medical/billing information to the following individuals:

Name(s) of authorized person(s)	Relationship to Patient	**Phone Number** & Information to be Disclosed

In signing this authorization, I understand and acknowledge the following (please initial by statement):

_____To the individual(s) listed above, Primary Care Associates is able to discuss or release information necessary for the purpose of treatment, coverage/benefit inquiries, claims/billing inquiries, appeals, health care operations and/or questions about my health care and I acknowledge that the information released may include individually identifiable health information about me.

_____This information is being made at my request.

_____I understand that this authorization is voluntary and that I may refuse to sign it.

_____I understand that my refusal to sign this authorization will not affect my ability to obtain treatment/care.

_____I understand that I may revoke this authorization at any time by notifying Primary Care Associates in writing and all future disclosures will then cease. However, such revocation will not affect any disclosures we have already made based on your prior consent.

_____I understand that once the disclosures authorized herein have been made the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.

_____I understand that unless otherwise revoked in writing, this authorization will expire one year from the date I signed it, as required by Kansas Law and will remain in part of my medical record.

_____I understand that as a patient I have a right to restrict the uses of the information but Primary Care Associates does not have to agree to those restrictions.

_____I acknowledge that Primary Care Associates provided me with a Notice of Privacy Practices.

_____ _____

Date Signature of Patient/Legal Representative

Legal Representative

Address:_____Telephone Number _____

Relationship to Patient:_____