Murray & Associates Family Healthcare

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Under the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**, I understand that I have certain rights to privacy regarding my protected health information. I understand that the following information can be used to:

- Plan, conduct and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Conduct normal healthcare operations such as physical and quality assessments
- Obtain payment from insurance carriers/ third-party payers

Please initial:

_____ I have been given the right as a patient to review the Notice of Privacy Practices prior to signing this consent. I understand that Murray & Associates has the right to change this Notice of Privacy Practices from time to time and that I may contact Murray & Associates at any time at the address listed above to obtain a current copy of Notice of Privacy Practices.

_____ I understand that I may request in writing restrictions of how my private information is used or disclosed to carry out treatment, health operations or payments. I also understand that the organization is not required to agree to my requested restrictions, but if agreed upon restrictions are granted.

_____ I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Please list all relatives, friends, in which we may discuss your results with:

Name	***Phone No.***	***Relationship***
_____	_____	_____
_____	_____	_____
_____	_____	_____

Release of Information

_____ I DO authorize Murray & Associates Family Healthcare to leave a message on the following: ***circle all that apply***: CELL PHONE / HOME PHONE

_____ I DO NOT authorize Murray & Associates Family Healthcare to leave any messages on telephone regarding any medical information such as test results and will take the responsibility of calling to make an appointment with provider for results face to face.

_____ _____

Patient signature/date Provider signature/date