HIPAA DISCLOSURE & RELEASE OF INFORMATION AUTHORIZATION FORM

Patients Last Name:	First Name:	Date of Birth:

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. Protected Health Information (PHI) may originate in my medical record at IKP, or may be received from outside health entities and filed in my medical record. I understand that this information can and will be used by IKP to: (a) conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly, (b) obtain payment from third-party payers, (c) conduct normal healthcare operations such as quality assessments and physician certifications, and (d) notify me of educational events specific to my medical condition(s) through IKP or networking organizations.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may obtain a current copy of the Notice of Privacy Practices from my local office, or by contacting the Privacy Officer at 1300 W. Terrell, Suite 405, Fort Worth, TX76104. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. 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.

____________________________________ ________________
Signature of Patient or other legally authorized representative Date

Phone Call Permission(s) and Preference(s)

☆ Preferred Phone #: ( ) -	Secondary Phone #: ( ) -
Please select one of the following: ☐ Leave message with detailed information ☐ Leave message with contact number only	Please select one of the following: ☐ Leave message with detailed information ☐ Leave message with contact number only

IKP Family Medicine has my permission to discuss my healthcare and/or make financial arrangements with the following individuals.

Name:	Relationship:
Name	Relationship:
Name:	Relationship:

Secure Patient Portal Permissions

I plan on registering or am already a portal user and IKP may communicate with me through the portal	YES	NO
Once registered IKP may use portal as my preferred reminder method	YES	NO
IKP has my permission to mail lab results to my home address	YES	NO

Email Address:

____________________________________ ________________
Signature of Patient or Guardian Date

Staff Initials _________