HIPAA/Prescription Consent Form

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| --- | --- |
| Patient’s Full Name: | Date of Birth:  |

I give Medical Associates of Maquoketa, PC my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, to view any past prescription histories, to transmit electronic prescriptions, and for health care operations like quality review.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice. I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for the information already used and disclosed. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

We request that payment be made at the time of service. Please be prepared to pay for your visit today. If you have a copay/co-insurance you will be asked to pay that amount. A photocopy of this assignment is to be considered as valid as an original.

I authorize Medical Associates of Maquoketa, PC to obtain/release or exchange information regarding demographics, appointments, insurance and medical information including test results with the following people:

|  |  |  |
| --- | --- | --- |
| Name | Phone Number | Relationship to Patient |
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|  |  |  |

Messages may be left on my answering machine regarding lab results, medical information and appointments. YES\_\_\_\_ NO\_\_\_\_

I can be contacted at my workplace. YES\_\_\_\_ NO\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Patient Signature | Relationship to Patient | Date |
|  |  |  |

*Your signature indicates that you have read and understand the above information. This form will expire 15 months from the date of signature.*

*For Office Use Only*

Witness Date