NOTICE OF ACKNOWLEDGMENT OF PRIVACY PRACTICES HIPPA FORM AND CONSENT

Our notice of privacy practices provides information on how we may use and disclose protected health information about you. The notice contains a Patients Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you have the right to obtain our current notice by contacting our practice. You have the right to request that we restrict how protected healthcare information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to the restriction, but if restriction is agreed upon it will be an honored agreement.

By signing this form you agree to consent to our use and disclosure of protected healthcare information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, signed by you. However, such revocation shall not affect any disclosure we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 [HIPAA].

I [_____], acknowledge I have received and reviewed the Notice of Privacy Practices for Dr. Michael Barry DO., FACC and Medical Providers of 'Ohana Cardiology. I understand I may waive to sign this acknowledgment.

PATIENT SIGNATURE: *please sign* _____ **DOB:** _____ **DATE:** _____

THE PATIENT UNDERSTANDS THE FOLLOWING:

Protected Health Information may be disclosed or used for treatment, payment or health care operations. The Practice has Notice Of Privacy Practices and the patient has an opportunity to review this notice. The Practice refuses the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of his/her protected health care information, but the practice does not have to agree to those restrictions. The patient may revoke this consent in writing, at any time, and all future disclosures will then cease. The Practice may condition receipt of treatment upon execution of this consent.

Check the box for your preferred contact method:

☐Cell Phone _____ leave voice mail: ☐YES ☐NO

☐Home Phone _____ leave voice mail: ☐YES ☐NO

☐Work Phone _____ leave voice mail: ☐YES ☐NO

☐Email: _____ ☐YES ☐NO

☐ Disclosure to communicate, discuss and organize your care with the following person(s) listed below. I also understand I may revoke this authorization in writing at any time:

Full Name: _____ Relationship: _____ Phone: _____

Full Name: _____ Relationship: _____ Phone: _____

COORDINATION OF CARE

Primary Care Physician: *please print* _____ Phone: _____

Referring Physician: *please print* _____ Phone: _____

Other Physicians: *please print* _____ Phone: _____

Podiatrist, Nephrologist, Endocrinologist, Pain Management, etc.

☐ Disclosure to communicate, discuss and organize coordination of care with above listed providers. I also understand I may revoke this authorization in writing at any time:

Signature: *please sign:* _____ Relationship: _____ Phone: _____

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS AND REQUEST MEDICAL RECORDS RELEASE

HIPAA laws allow the Clinic to include in a "medical record request" records that the providers at the Clinic used to make decisions about patients. These can include such additional items as medical records brought/sent to the Clinic by a patient from other healthcare providers, billing records, and/or registration papers. Many patients have found that they do not need all of these records as they have kept a copy of records provided to the Clinic from other healthcare providers, and have received insurance billing records directly from their specific insurance company. **Please Note** we require a signed Authorization to release Medical Records to be updated every 90-days.