

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. When you become a patient of ours, we create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. The **Health Insurance Portability and Accountability Act (HIPAA)** outlines privacy requirements. This acknowledgement form is a summary of our Practice Policies and a means for you to know your rights. HIPAA requires that you have access to our Practice Policies and that you must tell us the manner you want us to contact you regarding this information if necessary. This form will help you acknowledge and authorize these topics.

The policy of this office is to not disclose or discuss any of your Patient Health Information (PHI) with anyone or any entity other than those situations described by law that do not require prior authorization. These latter entities may include other physicians who may participate in your health care, insurance companies who will help pay for your care, Pharmacies, and health oversight government entities that have these legal jurisdictions. You also need to know that, according to HIPAA requirements, you may inspect and copy PHI and may request an amendment of PHI according to the rules set forth by HIPAA. In addition, you may request an accounting of the disclosures of PHI and may complain about alleged violations to the practice and DHHS. Forms for these are available at your request.

If you would like us to discuss your health information with anyone, you must authorize this disclosure. Otherwise, we will abide by our standard office privacy practice and not discuss your information with anyone or any entity, as stated above.

Authorization: By signing this authorization, I authorize Robert L. True, MD, PA or his staff to use and/or disclose certain protected health information (PHI) about me **to the following people or entities**, such as family, spouse, etc. (please list all names):

NAME OF ANYONE WE ARE ALLOWED TO SPEAK TO: _____

I also acknowledge that **I may revoke or amend these authorizations** at any time upon completion of a written amendment. This authorization will not expire unless defined on _____(Expiration Date or Defined Event).

Signature _____ **Date** _____

NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

The required HIPAA **Notice of Privacy Practices** for Robert L. True, MD, PA and True Aesthetics Center regarding **Protected Health Information (PHI)** are available for you to read and review. If you desire, you may receive a copy of these if you request this. In order to comply with the HIPAA law requirements, you must acknowledge the following:

I understand that I may read these "Notice of Privacy Practices" and receive a copy of them at my request. I also understand that I may request restrictions on certain uses and disclosures of PHI, and on how the practice communicates PHI. I understand that I may inspect and copy PHI and may request an amendment of PHI according to the rules set forth by HIPAA. I may request an accounting of the disclosures of PHI and may complain about alleged violations to the practice and to DHHS. I also understand the following: that when my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule; that the Practice may request payment or other remuneration from a third party in exchange for using or disclosing my information; that I do not have to sign this authorization in order to receive treatment from Robert L. True, MD; that I have the right to refuse to sign this authorization; that I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization; that my written revocation must be submitted to the Privacy Officer at 5203 Heritage Ave., Colleyville, TX 76034. I understand that I must designate the manner in which I prefer to be contacted regarding results of my health information. Therefore, **if necessary, I authorize the staff of Robert L. True, MD, PA and True Aesthetics Center to contact me via the phone numbers or the addresses listed below.**

Home Phone: _____ Work Phone: _____

Address _____ City _____ State _____ Zip Code _____

Signature: _____ **Date:** _____
Signature of Patient (or Legal Guardian) Relationship to Patient