



El Centro de Corazón

Name of Patient: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ MRN: \_\_\_\_\_-

**HIPAA Information and Consent Form**

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a “friendly” version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. [www.hhs.gov](http://www.hhs.gov)

El Centro de Corazón has adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files are saved in the Practice Management System electronically. The normal course of providing care means that, such electronic records may be left open in the computer, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of El Centro de Corazón to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. El Centro de Corazón utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the clinic manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both El Centro de Corazón and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
10. El Centro de Corazon is a nonprofit health organization that participates in the OCHIN Network. OCHIN supplies information technology and related services to El Centro de Corazon and other OCHIN participants. Your health information may be shared by El Centro de Corazon with other OCHIN participants of the organized health care arrangement.

I, \_\_\_\_\_ do hereby consent and acknowledge my  
(Print First and last name of patient OR Parent or Legal Guardian IF patient is a minor)

**agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

**Signature:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_ **Today's date:** \_\_\_\_\_  
(Patient Signature OR Signature of Parent or Legal Guardian IF patient is a minor)