PROJECT ACCESS NASHVILLE SPECIALTY CARE
A Program of the Medical Foundation of Nashville

Prefer to complete online?
Scan the QR code or use this link:
bit.ly/PANSC-HIPAA-English

HIPAA Compliance Patient Consent Form

Information

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have had the opportunity to review our notice before signing this consent. The terms of the notice may change, if so, you will be notified to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information, but the organization does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The organization may condition receipt of treatment upon execution of this consent.

Patient Response Required

May we phone, email, or send a text to you to confirm appointments? (circle one) YES NO

May we leave a message on your answering machine at the number below? (circle one) YES NO

Preferred Phone Number: _____

Preferred Email Address: _____

May we discuss your medical condition with another member of your family? (circle one) YES NO

If YES, please name the members allowed and their relationship to the patient: _____

_____

Signature Required

Patient's Full Name: _____ **Date of Birth:** _____

This consent was signed by (PRINT NAME): _____

Signature: _____ **Today's Date:** _____

Identify Signer:

☐ **Self** ☐ **Parent of Minor** ☐ **Guardian** ☐ **Other authorized representative (Explain):** _____

* Proof of legal authorization may be required.

Link to Notice of Privacy Practices in English: https://bit.ly/panhipaa-english

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