The Hand and Upper Body Rehabilitation Center
HIPAA CONFIDENTIALITY WAIVER

HIPAA CONSENT: I have read and understand the Notice of Privacy Practices. **YES___ NO ___**

NOTICE OF RIGHT TO CONFIDENTIALITY OF REPORTS & RECORDS: Under the Federal and State HIPAA laws, healthcare providers may not disclose reports of any disease or treatment, nor any records maintained under this law to any person who is not a member of this office or other specific limited circumstance. Reports and records include: examination, treatment, diagnosis and interviews. Also included is personal Protected Health Information identifying the patient and relating to past, present or future physical/mental health conditions, treatment or payment.

ACKNOWLEDGEMENT AND WAIVERS OF RIGHT TO CONFIDENTIALITY: I have read and understand the above information, and I understand my rights with regard to HIPAA privacy practices.

I HEREBY ELECT THAT MY HEALTH REPORTS AND RECORDS MAY BE RELEASED TO THE FOLLOWING INDIVIDUALS. In addition to face encounters, I also authorize that my health information may be disclosed to the individuals listed below via other means of communication including phone and mail.

_____ _____
NAME RELATIONSHIP

_____ _____
NAME RELATIONSHIP

_____ _____
NAME RELATIONSHIP

I understand that at any time, I may revoke this authorization and/or rename the authorized individuals. I understand that any revocation must be done in writing.
I UNDERSTAND THAT INFORMATION USED OR DISCLOSED UNDER THIS AUTHORIZATION COULD POTENTIALLY BE DISCLOSED BY THE PERSON RECEIVING THE INFORMATION, AND MAY NO LONGER BE SUBJECT TO THE PRIVACY PROTECTIONS PROVIDED TO ME BY LAW.
I understand that the Hand and Upper Body Rehabilitation Center may not require that I sign this authorization to obtain treatment.

_____ _____
PATIENT DATE

I hereby consent for the patient as parent or legal guardian of the patient if under 18 years of age.

_____ _____
SIGNATURE DATE

_____
PRINT NAME