SOLID OAK ADULT AND PEDIATRIC CLINIC

Patient Name: _____ DOB: _____

Any physician, staff, employee or representative of Solid Oak Adult and Pediatric has my permission to discuss and/or disclose information regarding my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information in order to facilitate and coordinate my care, treatment and payment with the following persons:

Contact Name: _____
Relationship to Patient: _____
Phone Number: _____

Contact Name: _____
Relationship to Patient: _____
Phone Number: _____

Contact Name: _____
Relationship to Patient: _____
Phone Number: _____

Communicator Automated Messaging Preferences
(Circle preferred)

Health Notifications	Email	Phone	Text Message
Appointments	Email	Phone	Text Message
Announcements	Email	Phone	Text Message
Billing	Email	Phone	Text Message

Consent to Call: Yes / No Consent to Text: Yes / No

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

This is a summary of our Notice of Privacy Practices. The entire text detailing our privacy practices is available for your review and we encourage you to read it and ask any questions you may have regarding our privacy practices. If you have any questions or would like to exercise any of your rights, please contact our Privacy Officer. After reviewing the material, please sign in the space provided below. The Privacy Act generally requires healthcare providers to take responsible steps to limit the use of disclosure of and request for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Health care entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record.
PATIENT RIGHTS: As a patient, you have a right to inspect copy, amend, request a restriction or revoke a prior restriction on the use and disclosure of your Protected Health Information (PHI). You may also request a copy of an accounting of disclosures, which will detail all disclosures made for reasons other than treatment, payment or health care operational purposes.
PROVIDER RIGHTS: As your health care provider, we can use or disclose your PHI for treatment, payment or health care operational purposes. Any other disclosure requires you to sign a specific authorization.
NOTE: Uses and disclosures for protected health information may be permitted without prior consent in an emergency.
ACHKNOWLEDGEMENT: I acknowledge that I have received Alabama Pediatric Gastroenterology, P.C. Notice of Privacy Practices.

_____ Audio and Video recordings are not allowed. We feel that such recordings interfere with medical treatment and the privacy of our staff and patients.
Initial

Signature: _____ Date: _____
(Patient's signature is required if over the age of 14)