

CONSENT FOR THE USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Jefferson Primary Care
116 East Third St.
Ranson, WV 25438
304-724-7200**

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

Patient Name: _____ Date: ____/____/____

Address: _____

Patient DOB: _____

Parent/Guardian: _____ Relationship to Patient: _____

Notice of Privacy Practices: You have the right to read our “Notice of Privacy Practices” before you decide whether to sign this consent. Our notice provides a description of the manner in which we may use and disclose your protected health information.

Purpose of Consent: I am giving consent to Jefferson Primary Care, P.L.L.C. to use and disclose protected health information to carry out treatment, payment activities and healthcare operations (including, but not limited to the transmission of protected health information to third-party payors and collections agencies, as required in order to obtain payment).

Information or Records to be Disclosed: Information relating to Patient’s health care information, appointments, communications, prescriptions, billing account and any other aspect related to my health care or the contents of my medical records.

Consent: As the person (i.e., patient) signing this authorization, I understand that I am giving my permission to the above-named health care entity/physician and M.E.D.I.C., Inc., the medical practice management company contracted to handle all billing issues for that health care entity/physician to disclose confidential health care information relating to my medical records, bills and patient/physician communications to the below-listed persons. I understand that my physician may not condition treatment or payment on my willingness to sign this authorization, absent specific legislatively mandated circumstances that must be explicitly set forth in this authorization, none of which have been included in this document. I also understand that I have the right to partially (for example, for one of the listed persons only) or entirely revoke this authorization at any time, but that my revocation is not effective until delivered in writing to M.E.D.I.C., Inc. and the named physician’s office. Further, any revocation shall not be effective to any disclosures already made pursuant to this consent form authorization. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included in my health records (in the event of disclosure of billing information to an authorized third party, a computerized notation of such discussion in the patient’s account shall be made rather than a document in patient’s official medical records). I understand that health information disclosed under this authorization might be re-disclosed by one of the recipients whom I authorized to receive the information. As a result of such a re-disclosure, I understand that my private and confidential health care information may no longer be protected to the same extent as such health information was protected by law when solely in the possession of my physician or other entities covered by federal law.

This consent will not expire (but may be revoked by me at any time).

Concerning Insurance: I hereby authorize Jefferson Primary Care, P.L.L.C. and M.E.D.I.C., Inc. to apply for benefits on my behalf for covered services rendered.

I certify that the information that I have reported with regard to my insurance coverage is accurate and current. I understand that my protected health information will necessarily be released in order to apply for these insurance benefits – i.e., to be used in treatment, payment activities and healthcare operations. I authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier(s) (or, in the case of Medicare Part B benefits, to the Social Security Administration and health care financing administration). A copy of this authorization may be used in place of the original.

I understand that I may revoke this consent at any time with written notice to both M.E.D.I.C., Inc. and Jefferson Primary Care, P.L.L.C.

Protected Health Information (including billing information) may be released to the following individual(s):

1. _____
2. _____
3. _____

I understand that I have the right to inspect and obtain copies of protected healthcare information (in accordance with federal privacy regulations 45 CFR 164.524)

I understand that I do not have to sign this consent and that my refusal to sign will not affect my eligibility for benefits.

I have the right to obtain a copy of this form.

Patient Signature: _____ Date: ____/____/_____