HIPAA Authorization Form

Anderson Walk-In Medical Clinic has taken measures to protect all of our patients' private medical information. We will not release any information to anyone unless you have provided the requested information below. These would be people other than what is covered in our Notice of Privacy Practices.

HIPAA (Health Insurance Privacy & Accountability Act) **does allow** us to release information to outside entities on your behalf. Example: Another medical office when making you an appointment, your insurance company when trying to get your claims paid, your pharmacy or hospital.

Please see the receptionist with any questions prior to signing this authorization form.

I, _____, **am authorizing** the person/people listed below to obtain medical information about myself. I understand that Anderson Walk-In Medical Clinic is not responsible for the information provided as long as it is given to a person that I have listed below.

Date of Birth must be provided so that our office can verify that we are speaking to the correct person.

Name:_____
Date of Birth:_____

Name:_____
Date of Birth:_____

Name:_____
Date of Birth:_____

Patient's Signature:_____ Date:_____

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I, _____, **do not** authorize Anderson Walk-In Medical Clinic to release **any** of my protected medical information to anyone other than the entities that are discussed in the Notice of Privacy Practices.

Patient's Signature:_____Date:_____

Consent to Use & Disclosure of Protected Health Information **(HIPAA)**

Your protected health information will be used by Anderson Walk-In Medical Clinic or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent. You may also request a copy of the Notice of Privacy Practices for your own records. See the receptionist and she will be happy to give you a copy.

You may request a restriction on the use or disclosure of your protected health information. Anderson Walk-In Medical Clinic **may or may not** agree to restrict the use or disclosure of your protected health information.

If Anderson Walk-In Medical Clinic agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the Federal Privacy Standards.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Anderson Walk-In Medical Clinic reserves the right to modify the Privacy Practices outlined in the notice.

I have reviewed this consent form & give my permission to Gateway Medical Center, Inc. to Use & Disclose my health information in accordance of the Federal Privacy Standards.

_____

Patient Name (Printed)

_____

Signature of Patient / Parent / Guardian

_____

Date