THE ENDOCRINE CENTER, PC
CONCIERGE MEDICINE

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and Virginia state law, I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:
• Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
• Obtain payment from third party payers.
• Conduct normal healthcare operations such as quality assessments and physician certification.

I hereby acknowledge that I have been informed by The Endocrine Center, PC of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review the Notice of Privacy Practices prior to signing this consent.

I understand that this organization has the right to change the terms of the Notice of Privacy Practices at any time, and that I may contact the Endocrine Center, PC, at any time, at the address listed below, to obtain a revised version of the Notice of Privacy Practices.

I also hereby authorize and consent to the use and/or disclosure of my protected health information so that The Endocrine Center, PC, can carry out treatment, payment and health care operations. For purposes of this document, protected health information means any and all information regarding the health care services provided to me by the Endocrine Center, PC, including information relating to services provided to me by other providers prior to this date.

I understand that I may request in writing that you restrict how my protected health information is used or disclosed to carry out treatment, payment or health care operations. I also understand that the Endocrine Center, PC is not required to agree to my requested restrictions, but if we do agree, then we will abide by those restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the Endocrine Center, PC has already taken action relying on the content of this consent. This authorization/consent will remain in effect until I provide a written notice of revocation to the Practice. The revocation will be effective immediately upon the Practice's receipt of my written notice.

_____ _____
Signature of Patient or Parent/Legal Guardian Date

_____
Printed name of person signing above