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HIPAA PATIENT COMMUNICATION FORM

FAMILY & FRIENDS: It is the policy of this office not to release confidential medical information regarding your treatment to family members or friends ***except for parent/legal guardians***; other persons authorized by the patient, as we may reasonably infer from the circumstances (e.g. if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment, in emergency situations, or as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below. By signing below, you **authorize** the following people to receive information regarding your treatment or care. *(If you wish to add names later on, please confirm this in writing).*

Spouse: _____ Yes _____ No _____

Parent: _____ Yes _____ No _____

Other: _____ Yes _____ No _____

Alternative communications: You are also entitled to specify alternative reasonable means of communication, if you do not wish to be contacted by us in a certain way.

Home (answering machine) **Yes _____ No _____** Work (answering machine) **Yes _____ No _____**

I HEREBY REQUEST THE FOLLOWING MEANS OF CONTACT ONLY: _____

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

Name of patient: _____

I hereby acknowledge that a copy of this medical practice's **Notice of Privacy Practices** is available in the reception area and that I may request a copy of any amended **Notices of Privacy Practices** at each appointment.

Informed Consent – I authorize:

- The Youth Fountain, LLC to forward any medical information to the referring physician(s) regarding [my/my child's] illness and treatment and to submit information to my employer and/or their insurance carrier (for worker's compensation only). I understand that the information released may include psychiatric, drug, alcohol, and/or HIV/AIDS information; the confidentiality of this record is protected by the Federal Confidentiality Regulations. This information shall not be forwarded to anyone else without my written consent or other authorization as provided in the statutes.
- The Youth Fountain, LLC to release to the insurance carrier any information needed for the payment of any claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignments.
- Payments to The Youth Fountain, LLC from my insurance carrier and agree to pay any applicable co=payments at the time of service. I understand that my health insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance.
- Testing and treatment procedures as deemed necessary by The Youth Fountain, LLC physicians.

I CERTIFY THAT I HAVE READ THIS AGREEMENT, THAT I AM THE PATIENT (OR LEGAL GUARDIAN FOR A MINOR), AND I ACCEPT THE TERMS AS ABOVE.

Patient Signature _____ Date _____

Guardian Signature _____ Relation: _____ Date _____

If you have been assigned guardianship of the minor patient, you must present proof of guardianship, such as a court document or DCF paperwork.