Georgia Breast Care

Notice of Privacy Practices & Patient Consent Authorization for Use & Disclosure of Protected Health Information (PHI)

Patient Name: _____ **Date of Birth:** _____ /____ /____ **Last 4 of SS#** ___ ___ ___ ___

STATEMENT

I understand that according to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 that I have certain patient rights regarding my protected health information. I understand that Georgia Breast Care, PC may use or disclose my protected health information for treatment, payment, or health care operations; which includes providing healthcare to me, the patient, handling billing and payment as well as taking care of other health care operations. The patient or legal custodian authorizes the Staff Physician(s), Nurse Practitioner, and/or Physician Assistant to examine and treat the above patient. I understand Georgia Breast Care will not condition my treatment on whether I provide authorization. This authorization will automatically renew. Georgia Breast Care, PC has a detailed document called the *Notice of Privacy Practices* which contains a more complete description regarding your rights to privacy and how we may use and disclose protected health information. I understand that I have the right to review the Notice of Privacy Practices before signing this agreement. If I ask, Georgia Breast Care will provide me with the most current Notice of Privacy Practices. With authorization, Georgia Breast Care may call, leave a message or a voice mail that will aid the practice in carrying out treatment, payment and health care operations. The patient has the right to revoke this authorization at any time in writing except to the extent that Georgia Breast Care, PC has taken action relying on consent. This authorization will remain in effect unless otherwise revoked by the patient. Release of the PHI covered by this authorization will be disclosed solely for the purpose of keeping designated family members informed of your healthcare condition.

ADDRESS:
Georgia Breast Care, PC
Attention: Practice Administrator
780 Canton Rd NE • Suite 410
Marietta, Georgia 30060

Phone: (678) 370.0370 Fax: (678) 370.0371

INDIVIDUALS TO WHOM YOUR HEALTH INFORMATION MAY BE DISCLOSED

☐ Spouse Name: _____ ☐ Parent Name: _____
☐ Child Name: _____ ☐ Parent Name: _____
☐ Child Name: _____ ☐ Other Name: _____

TYPE OF INFORMATION THAT CAN BE DISCLOSED

☐ **All** at doctor's discretion ☐ Medical History ☐ Diagnosis ☐ Treatment ☐ Surgical Information
☐ Billing/Insurance Information ☐ Other: _____

_____ _____
Patient or Authorized Signature **Date**

The personal health information contained on this form is intended only to aid in providing healthcare services to this patient. Any other use is a violation of Federal Law (HIPAA) and will be reported as such. If you have received this form in error, please contact our office at (678) 370.0370 and shred this document.