Phone: 480-575-0576 **Fax: 480-575-0512**
mdroomservice@yahoo.com **www.mdroomservice.com**

HIPAA PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.
As our patient we want you to know that we respect the privacy of your personal medical data and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.
We support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.
You may refuse to consent to the use or discloser of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please speak with Dr. Cohen.
You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Internet Medical Record Storage

I, the undersigned, hereby authorize the medical office of Joel Cohen, M.D., including but not limited to Dr. Cohen, his staff and his agents, to store medical and required related information about me on a secure off-site server. Communication of this medical sensitive and related non medical data will be done with encrypted transfer over lines (i.e., wire, wireless or cable) on the Internet.
I understand that I must specifically advise Dr. Cohen in writing if I do not want certain information about me stored in this manner.
Through this authorization, I am hereby irrevocably releasing the medical office of Joel Cohen, M.D. including but not limited to Dr. Cohen, his staff and his agents, from any and all liability for any damages or costs, or both, relating to or arising out of the storage of my medical records in this manner.
This authorization shall remain in effect until I specifically notify Dr. Cohen in writing that I no longer want medical information about me stored in this manner

Acknowledgement of Receipt of Privacy Notice

We are required by law to maintain the privacy of, and provide individuals with the notice of our legal duties and privacy respect to protected health information. If, after having read the HIPAA Notice of Privacy Practices, you have any objections to that form, please as to speak with our HIPAA Compliance Officer in person or by phone at the main office number.

Your signature below is an acknowledgement that you have received the Notice of our Privacy Practices.

Patient Name (Please Print) **Patient Signature**

___________________________________ ___________________________________