

ALL PRO HEALTH CENTER

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HIPAA Information and Consent Form

Dear Valued Patient,

The Health Insurance Portability and Accountability Act of 1996 provides safeguards to protect your privacy. These safeguards include restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you or your family with treatment. HIPAA provides certain rights and protections to you as the patient and us as the provider. We must balance these needs with our goal of providing you with quality service and care. Additional information is available from the U.S Department of Health and Human Services at www.hhs.gov.

We have adopted the following policies:

- (1) Patient information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care are handled appropriately. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.
- (2) It is the policy of our office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for our office and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology you might find valuable or informative.
- (3) Requirements for third parties to contractually comply with privacy laws.
- (4) You understand and agree to inspections of the office and the review of documents, which may include PHI by government agencies or insurance companies in the normal performance of their duties.
- (5) You agree to bring any concerns or complaints regarding privacy to the attention of the Doctor or office manager.
- (6) Your confidential information will not be used for the purposes of advertising or marketing of products, goods, or services.
- (7) We agree to provide the patient with access to their records in accordance with state law and federal laws.
- (8) We may change, add, delete, or modify any of these provisions to better serve the needs or both the practice and you as the patient.
- (9) You have the right to request restrictions in the use of your PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____, date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.