HIPAA Acknowledgement Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly. Most specifically to: (1) obtain payment from designated third-party payers, (2) conduct normal health care operations such as quality assessments or evaluations, prior authorizations, and provider certifications.

By my signature on the intake form, I consent to, and acknowledge that Harmony Haven may use and disclose my Protected Health Information (PHI) to carry out the following:

1. Plan and provide for my care and treatment.

2. Communicate to other healthcare professionals who may contribute or participate in my care and treatment.

3. Obtain authorization, confirm service provided and collect payment from third-party payers; and

4. Perform routine healthcare operations such as the review of records from healthcare professionals.

5. Notify law enforcement for danger to self or others- Tarasoff law.

I also consent to Harmony Haven to:

1. Leave a message at the phone number I provide, to assist the practice in carrying out routine healthcare operations such as appointment reminders, insurance items and any call pertaining to my clinical care.
2. Mail to my home or address provided by me any items that assist the practice in carrying out routine healthcare operations such as appointment reminders, test results, patient information forms and patient statements.

I understand that I have the right to request restrictions as to how my Protected Health Information (PHI) may be used or disclosed to carry out treatment, payment or healthcare operations, and that Harmony Haven is not required to agree to the restrictions requested.

I agree to review Harmony Haven Notice of Privacy Practices and acknowledge that a copy is available for printing and or downloading.

I understand that I will need to revoke this consent in writing, except to the extent that Harmony Haven may have already made PHI available to obtain payment from designated third-party payers or conduct normal health care operations prior to this request.

I acknowledge that I have read and understand all the above information and will answer the intake questions with correct and up-to-date information.