

## **PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM**

We at Harmony Health of WNY (the "Practice") are providing this Acknowledgment and Consent Form ("Consent") to you in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which provides guidelines to healthcare providers and other parties on safely sharing and protecting patient health information. By signing this Consent, you acknowledge that you understand its contents and you consent to our collection of your personal information, including individually identifiable health information (protected health information or "PHI") such as your name, address, social security number, and insurance information.

### **Use & Disclosure**

Signing this Consent also represents your consent to our use and disclosure of your private personal information, including PHI, to carry out your diagnosis, treatment, payment and health care operations. You are entitled to a copy of this Consent.

### **Notice of Privacy Practices**

Our Notice of Privacy Practices ("Notice") provides information about how we may use and disclose your protected health information. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review the Notice before signing this Consent, and by signing you acknowledge that you had the chance to review it. The terms of our Notice may change. If we change our Notice, we may notify you that a change has been made and you can obtain a revised copy by contacting our office.

### **Restrictions and Revocation**

You have the right to request that we restrict how PHI about you is used or disclosed. We are not required to agree to any restrictions, but if we do, we will honor that agreement. You may revoke this Consent in a signed writing, at any time, and all disclosures from that point on will cease. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

### **Protecting and Sharing Your Information**

We will do our best to protect all private personal information that we receive, yet the sharing of such information with us is at your own risk. Information used or disclosed pursuant to this Consent may be redisclosed by the Practice and may no longer be protected by federal or state law.

### **Conditions and Application**

The Practice may condition providing treatment to you upon your execution of this Consent. This Consent applies to any services the Practice provides or any interactions you have with us.

This Consent is signed by:

Patient or Representative: \_\_\_\_\_

Relationship to Patient (if other than patient): \_\_\_\_\_ Date: \_\_\_\_\_

**Harmony Health of WNY**

3545 Buffalo Rd. Ste 6  
Rochester, NY 14624  
**Tel:**585-684-3556  
**Fax:**585-360-1701

Dear Patient:

In compliance with HIPAA regulations, Harmony Health of WNY is committed to protecting your private health information. We need to know the names of the people that you will allow us to discuss your medical information, if any.

Please list below the names of the people that you will allow Harmony Health of WNY staff and providers to talk about your health and medical information, and then at the bottom write your name and sign to give us permission to do so.

---

Name	Relationship	Phone Number
------	--------------	--------------

---

Name	Relationship	Phone Number
------	--------------	--------------

---

Name	Relationship	Phone Number
------	--------------	--------------

---

Name	Relationship	Phone Number
------	--------------	--------------

---

Name	Relationship	Phone Number
------	--------------	--------------

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Printed Name \_\_\_\_\_ Date \_\_\_\_\_