Place Patient Label Here.

HIPAA COMPLIANCE REQUIREMENT – IGO

PATIENT CONSENT TO THE USE/DISCLOSURE OF PRIVATE HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my health care, IGO Medical Group originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

On occasion, IGO may have confidential health information about you, such as laboratory results, which we may wish to convey to you by telephone. Please indicate below how you would like us to handle this:

☐ Call this number (____) _____ - _____ to leave all health-related information.
Detailed confidential messages ☐ **may** ☐ **may not** be left at this number if answered by a machine.

☐ Write only, **do not call** (This means your doctor can **NEVER** call you, even with lab results).

My confidential health information may be discussed with the following people:

1. _____ 2. _____ 3. _____

My signature acknowledges that I have received a copy of the *Notice of Privacy Policies for IGO Medical Group Patients.*

NOTICE TO CONSUMERS:
Medical doctors are licensed and regulated by the Medical Board of California
800-633-2322 www.mbc.ca.gov

_____ _____
Patient's Signature **Date**

Printed Name _____

Address _____ Home Phone _____

_____ Cell Phone _____

Insurance _____ Work Phone _____
(Please show insurance card to receptionist)

Person to notify in case of emergency _____

Phone _____ Relationship _____

THIS WILL BE FILED IN YOUR MEDICAL CHART