

PRIVACY CONSENT FORM – 11/2009
Hawthorne Medical Associates, P.C.

Patient's name: _____ Date of Birth: _____
(please print)

- Signing this form indicates that you have received Hawthorne Medical Associates' (HMA) "Notice of Privacy Practices," (NPP) which contains complete information about the privacy policies and practices HMA uses to protect your personal health information.
- HMA may update the NPP at any time. The most current copy of the NPP is always available on our website: www.hawthornemed.com, or a paper copy is available upon request.

Our Notice of Privacy Practices states that we may disclose your protected health information (PHI) to others who may assist in your care, such as your spouse, children, parents or caregivers.

Please list any family members and caregivers with whom we are authorized to discuss your medical care or to whom we may release medical records or information.

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

Name: _____ Relationship to you: _____

OR - If you do not want us to release information to any family, friends or caregivers, please initial here: _____

Patient or legally authorized individual signature

Date

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

Your right to limit uses of Protected Health Information (PHI) for Treatment, Payment or Operations (TPO):

Under the terms of the NPP, you can ask HMA to limit how your personal health information is used or disclosed to carry out treatment, payment or health care operations. (All other uses must be specifically authorized by you). Only the Practice Administrator is authorized to agree to limitations to use of your PHI for TPO. We do not have to agree to your request, but if we do agree, we must follow the agreed limits. If you want to RESTRICT use/disclosure for TPO, please request a form or make your request in writing.

Your right to change this consent at any time:

You may change this consent at any time simply by completing a new form, or sending us a letter.

Your right to revoke this consent:

You cancel this consent in writing at any time by writing, signing, and dating a letter to HMA. The letter must say that you want to revoke your consent to authorize the use and disclosure of your personal health information for treatment, payment, and health care operations. If you revoke this consent, HMA does not have to provide any further health care services to you.