PRIVACY PRACTICE ACKNOWLEDGEMENT AND CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

Sylva Family Practice may disclose protected health information for its own treatment, payment and health care operations activities. I have been provided a copy of Sylva Family Practice's Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Sylva Family Practice has the right to change this Notice at any time. I may obtain a current copy by contacting the facility Privacy Official or by vising the web site at www.sylvafamilypracticepa.com.

We may we leave a voicemail on your home and/or cell phone number. We may also send a letter to the address we have on file. The information may include medical information; information necessary to schedule an appointment; lab results; prescription information; information needed to bill or submit claims to your insurance carrier. You may choose to use our secure patient portal at https://portal.sylvafamilypractice.com/login.htm. You can message your provider and our staff members via secure messaging, request a medication refill as well as view your lab results.

I consent to disclosure of protected health information about me to the following family member(s) or person(s) involved in my care or payment for my care. My consent will remain in effect as long as I am a patient of Sylva Family Practice unless and until I notify Sylva Family Practice in writing of any changes.

I have received the Notice of Privacy Practices and/or I have been provided an opportunity to review it.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of Patient or Representative Date

Please note: You do not have to add anyone to this list. You may add up to 4 names below if needed.

_____ _____

Print Name Relation & Phone Number

_____ _____

Print Name Relation & Phone Number

_____ _____

Print Name Relation & Phone Number

_____ _____

Print Name Relation & Phone Number

CONSENT TO FILE INSURANCE: I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me. I request that payment of authorized Medicare benefits be made either to me or on my behalf to physician/provider Sylva Family Practice, PA for any services furnished me by that physician/provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Print Name Date of Birth

_____ _____

Patient's Signature Date

(or parent or guardian's signature if patient is a child)

[1] Although allowed under HIPAA, North Carolina law does not permit release of PHI outside of the Hospital unless required by law, pursuant to a court order or patient authorization, or for treatment, payment, or health care operations purposes as defined and limited by HIPAA. There is no exception for family members except for residents of a nursing home. The North Carolina physician-patient privilege statute, N.C.G.S. § 8-53, and HIPAA allow verbal authorization or consent for release, respectively, of information to family members. However, the better practice is to document the patient's consent in order to have clear evidence of the patient's intent. The package does not include a consent or authorization to release PHI to other providers or to insurance companies or others since most providers already have such forms. The contents of this form can be combined with such existing consent forms.

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