HIPAA Policy, Consent, and Disclosure of Information

Patient Consent for Use and Disclosure of Protected Health Information

Patient Name: _____
Date of Birth: _____
Patient Address: _____
City, State, Zip Code: _____
Phone Number: _____

Notice of Privacy Practices

At Bloom Family Health & Wellness, we are committed to protecting your personal health information in compliance with the Health Insurance Portability and Accountability Act (HIPAA). This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review it carefully.

Uses and Disclosures of Protected Health Information (PHI)

Treatment

We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes sharing your information with other healthcare providers for continuity of care.

Payment

We may use and disclose your PHI to obtain payment for the healthcare services provided to you. This includes billing and collection activities, as well as verifying insurance coverage and benefits.

Healthcare Operations

We may use and disclose your PHI for healthcare operations, which include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, and conducting training programs.

Other Permitted and Required Uses and Disclosures

We may use and disclose your PHI in certain situations without your authorization, such as for public health activities, law enforcement purposes, and as required by law.

Patient Rights

Access to Records

You have the right to inspect and obtain a copy of your health records. Requests must be submitted in writing, and we may charge a fee for the costs of copying and mailing.

Amendments

You have the right to request an amendment to your health records if you believe the information is incorrect or incomplete. Requests must be submitted in writing and provide a reason to support the requested amendment.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your PHI. We are not required to agree to your request, but if we do, we will comply unless the information is needed to provide emergency treatment.

Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. We will accommodate reasonable requests.

Disclosure of Information Consent

I authorize Bloom Family Health & Wellness to disclose my protected health information to the following individuals or entities (e.g., family members, other healthcare providers):

1. **Name:** _____
   Relationship: _____
   Phone Number: _____

2. **Name:** _____
   Relationship: _____
   Phone Number: _____

3. **Name:** _____
   Relationship: _____
   Phone Number: _____

4. **Name:** _____
   Relationship: _____
   Phone Number: _____

I understand that I have the right to revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization.

Patient Consent and Acknowledgment

By signing below, I acknowledge that I have received, read, and understand the Notice of Privacy Practices provided by Bloom Family Health & Wellness. I consent to the use and disclosure of my PHI for treatment, payment, and healthcare operations as described in the Notice of Privacy Practices. I understand that I have the right to request restrictions, access, and amendments to my PHI as outlined above.

Signature of Patient or Legal Guardian: _____

Printed Name of Patient or Legal Guardian: _____

Date: _____