Atlanta Integrative & Internal Medicine

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Intake Document: HIPPA, Communication, Consent to Treat

I, _____, have been informed that a copy of *Crabapple Integrative and Internal Medicine*'s **Notice of Privacy Practices**, is posted in the waiting room area. A copy of this **Notice** will be furnished to me upon my request.

Patient Signature_____ Date_____/_____/_____

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996, (a Federal Law). Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding: unique identifiers for health plans, providers, individuals, employers, healthcare transaction & code sets for transmitting data electronically, privacy regulations over disclosure and use of health information.

It is our policy to **not** release confidential and/or unauthorized information except appointment confirmation by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone.
If you would like to have information released to someone other than yourself, please complete the following

Communicating your personal health information (PHI)
I authorize *Crabapple Integrative and Internal Medicine* to leave medical information pertaining to my care by the following methods and will assume responsibility to notify the clinic whenever this information changes.

Home Telephone	□ YES	□ NO	Home - Voice Mail/Answering Machine	□ YES	□ NO
Email	□ YES	□ NO	Cell Phone/Voice Mail	□ YES	□ NO
Work Telephone	□ YES	□ NO	Other:_____	□ YES	□ NO

May we fax medical records for your referrals? □ YES □ NO

Please list names of people with **whom we may discuss your medical care**:

Spouse Name _____	□ YES	□ NO
Parent Name _____	□ YES	□ NO
Other Name _____	□ YES	□ NO

REQUEST FOR MEDICAL CARE: I voluntarily consent to examination, lab evaluation, treatment and the rendering of care, including treatments and performance of diagnostic procedures. I grant my consent for treatment for myself, my spouse, or my minor child/dependent as listed on this form and all other medical documents submitted.

Patient Name: _____

Patient Signature: _____

If patient is a minor: Guardian #1 or Mother Signature: _____

Guardian #2 or Father Signature: _____

Date: _____