

AUTHENTIC HEALTH

Patient Privacy Directive

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers. We update this information yearly as required by the Department of Health and Human Services, to remain compliant with HIPAA regulations and maintain current patient contact information and authorization.

We may make your protected health information available electronically through an electronic health information exchange to other health care providers that request your information for their treatment purposes. In all cases the requesting provider must have or have had a treating relationship with you. Participation in an electronic health information exchange also lets us see other provider's information about you for our treatment purposes.

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, billing, appointments or administrative operations related to treatment and payment as designated by each section. I understand that the identities of each designated party must be verified before the release of any information.

My Rights: I understand that I do not have to sign this authorization form in order to receive health care treatment. I may revoke this authorization by writing a letter to Vickery Family Medicine, PLLC DBA Authentic Health Family Care and Precision Medicine. I realize that revocation will not affect any actions already taken based upon this authorization and that revocation may not be possible if the purpose of authorization was to obtain insurance. Once protected health information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient Phone # where we may leave clinical/admin/treatment messages: _____

Please provide the name(s) and phone number(s) with whom we may leave the following (indicate yes or no)

Name & Relationship to Patient	Phone Number	Leave Messages: Appointments	Leave Messages: Treatments	Speak To: Appointments	Speak to: Treatments

****You must inform us in writing of any changes in your directives.****

To be completed annually, at the time of first visit or when renewing HIPAA notice.

I certify that I have been given the opportunity to review my patient information, such as my address, phone number, and emergency contact person, and that all demographic information in my electronic health record is true and current. I also certify that the above listed individuals may be contacted regarding my care as I have specified.

Patient signature: _____ Date: _____