PRINCETON PRIMARY & URGENT CARE CENTER

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PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatments, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI).

You have the right to review our privacy notice, request restrictions and revoke consent in writing. If you choose to give consent to disclose all or part of your PHI to another individual, please indicate below. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

☐ I understand and agree to this privacy policy. *Date*: ________________________________

Print Name: _____________________________ *Signature*: _______________________________

☐ I allow ☐ all or ☐ part (please specify below) of my PHI to be discussed with:

Name of Individual: _________________________________ *Relationship*: ___________________

Patient/Guardian Signature: ____

Specific Information to be Disclosed: ____