SKYPOINT
MEDICAL

Acknowledgement of receipt of notice of Privacy Practice

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations

Treatment: The Practice may release/obtain any and all your medical records concerning your care to/from other health care professionals., physicians or hospitals providing care to you at any time. Payment activities: The practice may release any and all of your records to Medicare, Medicaid, any insurance companies, third party payer or managed care company.

Healthcare Operations: Your Physician or staff of the practice may discuss your condition with members of your family or other individuals named by you below **. We may attempt to contact you at the phone number you have provided to us and we may leave message on your voice mail or answering machine device concerning appointments or tests results. In accordance with Federal Government privacy rules implemented through the Healthcare Portability Act (HIPPA), you have the right to read our Notice of privacy Practices before you decide whether to sign this consent. Our notice provides a description of the uses and disclosures we may made of your protected health information. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our Privacy Practices as described in our Notice of Privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions at any time by contacting: Skypoint Medical Center at 847-882-1438

Right To Revoke: You will have the right to revoke this Consent at any time by giving us the written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent Will Not affect action we took in reliance on this consent before we received your revocation and that we may decline to treat you or continue to treat you if you revoke this consent. I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

PRINTED NAME *

Initial's *

By Initialing Above, I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Date *

ACKNOWLEDGEOF RECIEPT AUTHORIZATION FOR DISCLOSURE / NOTICE OF PRIVACY PRACTICES

-The above names patient acknowledges receipt of Skypoint Medical Center Notice of Privacy Practices. The notice of Privacy Practices provides detailed information about how the practice may use and disclose a patient's confidential information.
-The above names patient understands that the practice reserves the right to change the privacy practices that are describes in the notice. The patient also understands that a copy of any revised notice will be provided or made available to the patient.

I authorize Skypoint Medical Center to leave a voicemail Message for me at this phone number :

() Yes ()No Phone Number: _____

Name(s) of person (s) that I authorize disclosure of my health/ financial information :

Name:_____ Relationship:_____ () Health ()Financial

Name:_____ Relationship:_____ ()Health ()Financial

Patient / Authorized Person Signature:_____ Date:_____

AUTHORIZATION FOR TREATMENT OF A MINOR BY DELEGATED PERSONS

Patient Name:_____ **DOB:**_____

I hereby authorize that the following person has my permission to seek medical treatment (*) of the above name minor child on my absence and that his/her protected health information(**) may be shared.

Name _____ Relationship_____ Phone # _____

Please Circle One:
() Short term Authorization (30 days held at reception desk) ( )Long term Authorization (in effect until revoked in writing)

IT IS MY RESPONSIBILITY TO NOTIFY SKYPOINT MEDICAL CENTER OF ANY CHANGES AND TO COMPLETE A NEW FORM

Signature of Parent / Legal Guardian / Personal Representative: _____ _____

Relationship_____Date _____

(*) Medical treatment includes physical exam, routine radiology and laboratory tests and immunizations
(**) Protected health information includes but is not limited to test results, diagnosis, treatment and billing information. Highly confidential information will not be released unless the parent/legal guardian has also completed an Authorization of Release of Confidential Health Information Form. This information includes mental illness or developmental disability , psychotherapy notes , HIV or AIDS testing or treatment (including information regarding test ordering , performance or results, regarding if the results were positive or negative) , sexually transmitted disease , substance abuse , abuse of an adult with a disability, sexual assault, child abuse or neglect, genetic testing.

CONSENT FOR TREATMENT/AUTHORIZATION FOR REALEASE OF INFORMATION/ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

-I consent to the examination, treatment and procedures that may be requires during my office visit. I authorize any emergency care that is deemed necessary by the physician during my visit.
- I authorize Skypoint Medical Center to release to my insurance company or its representatives, any information regarding my diagnosis or records of any treatment or examination rendered to me that is required to process my claims for benefits.
-I authorize and request that my insurance company pay directly to Skypoint Medical Center the amount due to me in pending claims for medical treatments or services, by reason of such treatments per services rendered to me. This assignment will remain in effect until revoked in writing.
-It is understood that I am directly responsible for services rendered which are not paid my by insurance. I certify that to the best of knowledge, the information contained in this patient registration for is correct and true, I will notify Skypoint Medical Center in case of any changes in the information contained on this form.

Patient/Authorized Person Signature:_____ **Date:**_____