Abigail Enelow Myers, MN, ARNP

HIPAA CONSENT FORM

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please read and sign below.

HIPAA was introduced in 2003 as a federal law ensuring privacy practices by your practitioner.

This is a promise to protect your information. The rules below describe how your medical information may be disclosed by me, ABIGAIL ENELOW MYERS MN, ARNP as well as your rights with respect to this. Please feel free to call me if you have questions at 206-522-3543.

During each appointment I record clinical information that is stored in your chart. The record includes a description of your symptoms, recent stressors, medical problems, a mental status exam (MSE), and any relevant lab test results. In addition, a diagnosis is provided, treatment, and a plan for future care. This medical record is used as a:

- Basis for treatment planning
- Means of communicating with other providers involved with your care
- As a legal document of the care you receive
- A means by which a third-party payer (health insurance company) can verify that the services you received were appropriately billed and
- As a tool for assessing the ways that I provide care and how to improve this provision.

Health Information Rights

The following are your rights with respect to your medical record:

- The right to obtain a copy of this notice
- Authorization (i.e. ROI) signed by you to release your health information to other providers involved, insurance companies (I provide a summary, not the entire record)
- You may request a copy of your medical record at any time. If you believe that the information within the chart is inaccurate or incomplete, and changes will be made.

My responsibilities are:

- I am required by law to protect your information
- I may disclose to other providers who are involved in your care
- In order to collect payment for my services I must provide a diagnosis to your insurance company
- I will not share your medical info to your family or friends without your authorization
- I am required by law to provide information without your consent if I believe you are in danger or a danger to others
- My bookkeeper will have access to a very limited amount of information which is just your diagnosis

Please sign and date below:

I have read and consent to the above:

Signature: _____ Date: _____

Printed name: _____

Relationship to patient (if other than patient): _____