Redemption Psychiatry

Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use and disclosure of _____'s Protected Health Information by Redemption Psychiatry for the purpose of diagnosing, providing treatment, obtaining payment for health care bills or to conduct health care operations of Redemption Psychiatry. I understand that the diagnosis or treatment by Redemption Psychiatry may be conditioned upon the consent as evidenced by the authorizing signature on this document.

Use and disclosure of protected health information is regulated by a federal law known as 'The Health Insurance Portability and Accountability Act of 1996' ("HIPAA"). Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

By signing this consent form I acknowledge receipt of the Notice of Privacy Practices. Furthermore, I am agreeing that Redemption Psychiatry can request and use my prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

I understand I have the right to request a restriction as to how protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Redemption Psychiatry is not required to agree to the restrictions that I may request. However, if Redemption Psychiatry agrees to a restriction that I request, the restriction is binding on Redemption Psychiatry. I have the right to revoke this consent, in writing, at any time, except to the extent that Redemption Psychiatry has taken action in reliance on this consent.

The patient's "Protected Health Information" refers health information, including his/her demographic information, collected from the patient and created or received by his/her physician, another health care provider, a health plan, an employer or a health care clearinghouse. This protected health information relates to past, present or future physical or mental health or condition and identifying information, or there is a reasonable basis to believe the information may personally identify the patient named above.

I understand I have a right to review Redemption Psychiatry's Notice of Privacy Practices prior to signing this document. Redemption Psychiatry's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of protected health information that will occur in treatment, payment of bills, or in the performance of healthcare operations of Redemption Psychiatry. This Notice of Privacy Practices also describes client rights and Redemption Psychiatry's duties with respect to protected health information.

Redemption Psychiatry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

By signing this agreement, I am acknowledging that I have read, understand, and agree to adhere to Redemption Psychiatry's Clinic Policies and Procedures in regards to Registration Policy, Registration Procedure, No Show/Cancellation Policy and Procedure, Billing Policy and Procedure, Administrative Services Listing, and Termination Policy and Procedure. A print out of the policies and procedures is available upon request or can be found on redemptionpsychiatry.com under Patient Forms.

_____
Signature of Patient/Parent/Legal Guardian

_____
Print Name

_____
Date