DWH Medical Center, PC
Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect. The Health Insurance Portability and Protection Act (H.I.P.P.A.) require that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe.

DWH Medical Center requests that each patient signs this form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Signature of Patient/Representative: _____Date: ____/____/_____

Print Name of Patient/Representative: _____ Date of Birth: _____

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call, request the results of test and procedures, as well as being in room when procedures are being done. Under the requirements for H.I.P.P.A. we are not allowed to give any information or do any procedures in front of members without the patient's consent. If you wish have your test results released or perform medical procedures with family members present you must sign this form. Signing this form will only give consent to release Laboratory and Radiology results indicated or performance in the medical room with the doctor that are indicated below. This consent form will not allow DWH Medical Center to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize DWH Medical Center to release my laboratory/radiology results report and consent to be present in medical room to the following members.

1._____ Relation to Patient: _____ Date: _____

2._____ Relation to Patient: _____ Date: _____

Print Name: _____ Patient Signature: _____

Authorization to Leave Messages with Household Members/ Answering Machine

From time to time it is necessary for representative of DWH Medical Center to leave messages for patients. The purpose of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call DWHMC regarding an issue or concern. At no time will a representative of DWHMC discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name:_____

Patient Signature: _____ Date:_____