Karim HealthCare

HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy about my Protected Health Information. I understand that the information can and will be used to:

- Conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of our Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to read and review and request a copy of your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the Privacy officer to obtain a current copy of the Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are required to agree to my restricted restrictions, and if agreed, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have acted relying on this consent.

Patient Name (printed): _____ Date of Birth: _____

Signature/Date: _____

Relationship to Patient (if minor): _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ An emergent situation prevented us from obtaining acknowledgement
- ☐ Other (Please be Specific): _____

Effective Date: September 23, 2013