White Oak Psychiatric Associates

HIPAA NOTICES OF PRIVACY PRACTICES

All specialists are required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practices with respect to your health information. A copy of the WOPS privacy practices is available to you upon request.

_____ _____

Patient Signature Date

_____

Print Name

PATIENT CONSENT FOR RELEASE OF MEDICAL INFORMATION

In order to protect your confidentiality and to comply with government regulations (HIPAA). WOPS is required to obtain authorization from you in order to leave messages and/or provide information regarding your care with any person(s) other than you.

Please list any individual that we may release information regarding you, your mental treatment, and your history. It is not necessary to list physicians, only family members or friends.

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

I give consent to the physicians and staff of WOPS to leave messages or discuss scheduling, appointments, treatment, prescriptions, and other information regarding my care as follows:

Home Phone: Answering Machine or Voice mail	Circle	YES	NO
Cell Phone: Answering Machine or Voice mail	Circle	YES	NO
Consent to obtain Medication History	Circle	YES	NO
Consent to share data with Health Information Exchange	Circle	YES	NO

Health Information Exchange allows health care professionals and
patients to appropriately access and
securely share a patient's medical information electronically

I am aware that video only (no audio) cameras are installed in rooms for provider and patient security.

_____

Signature