Use and Disclosure of Protected Health Information

PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Please read and sign BOTH sections!!!!!

Acknowledgement of Notification

The educational pamphlet entitled, **"Notice of Privacy Practices,"** provides information about **Drs. Takai, Hoover, Hsu and Associates** may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996(HIPPA).

Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, you will be notified on your next visit to our office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

By signing below, you acknowledge receipt of our **Notice of Privacy Practices**.

_____ _____

Parent/Guardian Signature **Date**

Consent for Use and Disclosure of Information

By signing below, 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 trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to **Drs. Takai, Hoover, Hsu and Associates** for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at time of service in accordance with the contracted Insurance Carrier agreements.

_____ _____

Parent/Guardian Signature **Date**

_____

Parent/Guardian - Print Full Name

_____ _____

Patient Name – Print Full Name **Date**