Lakeside Primary Care
Written Acknowledgement and HIPAA Consent Form

I, _____ , *(Please print patient name*) have been provided with, and/or have had an opportunity to read, Lakeside Primary Care's Notice of Privacy Practices.

I understand that I may ask questions of the medical practice if I do not understand any information contained in the Notice of Privacy Practices.

HIPAA is the Health Insurance Portability and Accountability Act of 1996. 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 of Privacy Practice before signing this consent. As provided in our notice, privacy practices may change in accordance with changes in Federal regulations. A current copy may be obtained by requesting one from a member of our staff.
You have the right to request that we restrict how protected health information is used or disclosed. Please list below all the people you give us permission to disclose your protected health information to. (*Please note: We will not discuss any information with anyone not listed on this form.)*

Name	**Relationship**	**Is this person your *legal* POA?***	**May Discuss Billing Issues**	**Disclose information ONLY in Emergencies?**
		❒Y ❒N	❒Y ❒N	❒Any Information ❒Emergency ONLY
		❒Y ❒N	❒Y ❒N	❒Any Information ❒Emergency ONLY
		❒Y ❒N	❒Y ❒N	❒Any Information ❒Emergency ONLY
		❒Y ❒N	❒Y ❒N	❒Any Information ❒Emergency ONLY
		❒Y ❒N	❒Y ❒N	❒Any Information ❒Emergency ONLY

**** POA = Power of Attorney***

Lakeside Primary Care may leave lab results and/or test results on my home or cell phone voice mail.
❒*Yes* ❒*No*

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient: _____ Date: _____