

# Jon F. Geers, MD

## General Surgeon

188 State Road 129 S., Batesville, IN 47006

### PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate, we provide the minimum information necessary in regards to your health, treatment, payment or health care operations.

We also want you to know we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information. If you choose to give consent in this document, at some future time you may request to refuse all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### RELEASE of INFORMATION

Occasionally, you may want our office to release information to family members or friends who call to inquire about your care (i.e. caretakers, someone whom we may leave a message with concerning a procedure date/time.) Please list anyone whom you would like to give us permission to disclose information concerning your health care.

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

I give my permission for the release of my health information to the above listed individuals.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_