Candler Internal Medicine

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Candler Internal Medicine Patient HIPPA Consent

Patient's Name: _____ **Date of Birth:** _____

I understand that the patient's health information is private and confidential. I understand that Candle Internal Medicine works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Candler Internal Medicine may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations.

I understand that Candler Internal Medicine utilizes an electronic medical record system. I understand that this system is maintained in accordance with HIPPA and other patient privacy and health information management regulations. I understand that my healthcare providers will have access to my healthcare information across the continuum of my care.

Understand that Candler Internal Medicine utilizes an electronic prescribing mechanism for electronic transmission of prescription to my local Pharmacies and mail order pharmacies.

In the event that a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (Human Immunodeficiency Virus), Hepatitis B Virus, or Hepatitis C Virus, I consent to the testing of my blood and body fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed, as required by Georgia Law.

Candler Internal Medicine has a detailed document call "Notice of Privacy Practices" that contains more information about policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

Candler Internal Medicine may update this "Notice of Privacy Practices". If I ask, Candler Internal Medicine will provide me with the most current "Notice of Privacy Practices". This notice is also in the waiting room.

My signature below indicates that I have been given the chance to review a current copy of Candler Internal Medicine's "Notice of Privacy Practices". My signature means that I agree to allow Candler Internal Medicine to use and disclose the patient's personal information to carry out treatment, payment, and health care operations.

Name of person signing: _____ Date: _____
Signature: _____ Relationship to Patient: _____
Relationship to patient id signed by anyone other than the patient (Parent, legal guardian or other authorized representative only)