Privacy Practices Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

What this is about: There are restrictions on who may have access to your Protected Health Information (PHI). These restrictions do not include the normal exchange of information necessary to provide you with the office services. Fox Valley Psychiatry balances these privacy needs with our goal of providing you with quality care. More information about HIPAA is available at: www.hhs.gov

Fox Valley Psychiatry has the following policies:

1. Patient information will be kept confidential except as is necessary to provide patient care and administrative services. This includes the sharing of information with other healthcare providers that you consent to caring for you, laboratories, billing associates, and health insurance payers as is necessary and appropriate for your care. Patient PHI predominately will be kept in a secure online medical record program. Some paperwork may be stored in file folders temporarily in administrative areas such as the front desk, appointment room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. You may be contacted by telephone, text, email or U.S mail to communicate information to you. Including informing you about changes to office policies, to pay bills or for reminders about your appointments.
3. The practice utilizes billing vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising.
7. You will be provided with access to your records in accordance with state and federal laws.
8. Fox Valley Psychiatry may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request changes in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, , do hereby consent and acknowledge my agreement to the terms set forth in the NOTICE OF PRIVACY PRACTICES and any subsequent changes in office policy. This consent shall remain in force from this time forward until I no longer receive care from Fox Valley Psychiatry.

Signature (Patient Or Person Authorized To Give Consent)	Printed Name	Date
If signed by person other than patient: print name, relationship to patient, reason for alternate signing		