HIPAA CONSENT FORM FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient information will be maintained by Zack Hall, MD PLLC as described by the Notice of Privacy Practices and in compliance with federal and state regulation. You may obtain a copy of the Notice of Privacy Practices by request at any time.

Zack Hall, MD PLLC reserves the right to release your healthcare information based upon a decision by your physician for medical emergency situations and in general for continuity of care. We will release you healthcare information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone else that you elect in writing to receive it. We will release information related to your care regarding prescriptions to your pharmacy.

We reserve the right to:

- Call you to remind you of your next appointment and/or leave information about the appointment on your answering machine

Please list the number(s) and email that we can use to contact you:
Phone number(s):_____
Email address:_____

Lab results and other medical record documents will only be sent via email per request with your understanding that Zack Hall MD PLLC is not responsible for the security of your information once it leaves this office.

Authorization to release information:
The following individuals may have access to all medical record information
Please list the names and relationship to you

_____

Please initial here if you prefer that no one have access to your records _____

I have read and understand my rights, and how my information will be used and transmitted.

_____ _____ _____
Patient or Patient Representative's Signature | Patient or Patient Representative's Printed Name | Date of Birth

_____ _____
Address | Date Signed

_____ _____
Witness Signature | Date Signed

Authorization for Insurance Assignment

I hereby authorize payment of the medical benefits, if any, otherwise payable to me, directly to Zack Hall, MD PLLC for services rendered as described. I understand that I am responsible for payment for non-covered services as indicated by my insurance benefits. I also authorize the Physician to release any protected health information acquired in the course of my treatment that is necessary to process insurance claims.

By signing below I authorize that I have read and agree to the conditions of assignment

Signature:_____ Date: _____