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Notice of Privacy Policy Consent Form

HIPAA

Due to the Health Insurance Portability & Accountability Act (HIPAA), Virginia Child Neurology Specialists requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital, and insurance company. By signing this form, you acknowledge the receipt of our Notice of Privacy Practice provided by Virginia Child Neurology Specialists. By you signing this form, you also consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations.

Printed Name of Patient: _____

Signature of Patient/Responsible Party: _____

Date: _____

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents, or others to call and request the results of tests and procedures. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your health information released to family members or others, you may do so with your signature on this form.

I authorize Virginia Child Neurology Specialists to leave detailed messages/voicemails with the individuals listed below related to specific appointment information, laboratory/pathology results, patient instructions, follow-up care descriptions, prescription refill status, referral, billing, collections, and insurance information.

I authorize Virginia Child Neurology Specialists to leave a detailed message on my:

Home: __Yes __No **Cell:** __Yes __No **Business:** __Yes __No

**** If permission is not granted, only the date, time and location of your appointment will be left on your answering machine/voicemail.**

I authorize Virginia Child Neurology Specialists to release information regarding my neurologic health to the following individuals:

1. _____

   Relation to Patient: _____ Phone: _____

2. _____

   Relation to Patient: _____ Phone: _____

Signature of Patient/Responsible Party: _____Date: _____

I **do not** wish to have my health information release any person other than myself.

Signature of Patient: _____Date: _____

You have the right to revoke any of these consents, at any time, in writing, to Virginia Child Neurology Specialists. 5102 West Village Green Drive, Suite 109, Midlothian, VA 23112.