COLUMBIA FERTILITY ASSOCIATES

Patient Privacy and HIPAA Protection Form

Patient Name: _____ Date of Birth _____

Maintaining the privacy of your information is paramount at Columbia Fertility Associates (CFA). In support of CFA's compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy regulations, we established our **Notice of Privacy Practices ('Notice').** The Notice describes the ways in which CFA may use and disclose your medical information (called "Protected Health Information" or "PHI") and to inform you of your rights with respect to PHI in our possession. CFA limits the use and disclosure of your PHI to the minimum amount necessary. When release of PHI is required our staff will seek your written authorization prior to release and maintain a record of all PHI disclosures. A copy of the Notice can be provided for your review ant registration and can be accessed at the CFA website.

To ensure your understanding of CFA's Patient Privacy and HIPPA Protections, please review the following consents and authorizations, and acknowledge with your dated signature where requested – Thank you.

Consent for Disclosure of Protected Health Information:

As permitted by the Privacy regulations, CFA will use your Protected Health Information to carry out Treatment, Payment and Healthcare Operations. This may include sharing PHI with your health insurance plan(s), other healthcare providers involved in your care, as well as persons you designate below. Please refer to our "Notice of Privacy Practices" for a more complete description. You have the right to revoke this consent at any time by notifying us in writing to the attention of the Privacy Office, located at: 2440 M St NW, Suite 401, Washington, DC 20037.

I consent and authorize Columbia Fertility Associates to: (i) contact my healthcare providers to release information related to my care, and (ii) use and disclosure of my PHI for treatment, payment and healthcare operations.

_____ _____

Patient (Guardian) Signature Date

Designation of Other Caregivers or Personal Representative for Disclosure of PHI:

I hereby authorize and designate that CFA may disclose my health information to Other Caregivers or Personal Representative (designated Below) since such person(s) are involved with my health care or for payment of my care. CFA will, based on professional judgment, disclose the minimum amount of PHI necessary relevant to their involvement with your health care or request. Only person identified below will be permitted access to your PHI. If you do not want to designate anyone to have access to your PHI other than yourself, please initial _____.

"Designee" Print Name	Relationship to Patient	Phone – Contact

Acknowledgement of Review and/or Receipt of Practice's Notice of Privacy Practices:

I acknowledge that I was provided the opportunity to review the Practice's Notice of Privacy Practices ("Notice"), and if requested, a copy of the Notice has been provided. I understand the terms of the Practice Notice are subject to change and that I may request an updated copy of the Notice anytime from the CFA staff or by contacting the Privacy Office at the address above or via email at **bleonard@columbiafertility.com.**

_____

Patient (Guardian Signature Date

CFA Staff: I made a good faith effort to obtain a written patient acknowledgement of Notice receipt but was unable due to: Patient unable to sign _____Other_____Employee initials _____Date _____