

Receipt of Notice of Privacy Policies & Consent Form

Dr. Ellen Merkin
222 South Rainbow Boulevard, Suite 119
Las Vegas, Nevada 89145
(702) 363-7372

Patient Name: _____

Patient Phone Number: _____

Patient Address: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Dr. Merkin.

Signature

Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient

Print Name

Source of Authority: _____

Authorization Form

Dr. Ellen Merkin
222 So. Rainbow #119
Las Vegas, Nevada 89145
(702) 363-7372

Authorization for Release of Identifying Health Information

Patient Name: _____

Patient Phone Number: _____

Patient Address: _____

The professional office named above is authorized to release health information identifying _____ under the following terms and conditions:

1. Detailed description of the information to be released. _____
2. To whom the information will be released. _____
3. The purpose for the release. _____
4. Expiration date or event. _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. You can also review your health information that we have on file, before deciding whether to sign this authorization. Our *Notice of Privacy Practices* explains how you may request access to your identifiable health information, and how we may respond. You simply need to send a written request to the office contact person, listed above, to initiate the process.

If you sign this authorization, you can revoke it later, except if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office.

When your health information is disclosed as provided in this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes. .)

We will not receive a financial benefit from disclosing this health information about you. I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described above.

Signature

Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient

Print Name

Source of Authority: _____