Boone County Family Medicine

Explanation of Disclosure, Privacy Practices, Consent and Authorization Form

I. Permission for Verbal Disclosure

The patient is giving BCFM permission to verbally disclose information to the people they list below. The patient puts a check mark by the information which BCFM can disclose to the people listed above. This is required by HIPPA regulations so we do not disclose protected health information to people unauthorized by the patient.

II. Permission for BCFM to Leave a Message

The patient is giving, or not giving, permission for BCFM to leave a message for them on a work, home, and/or cell phone in regards to contact information for a call back. This again is required by HIPPA regulations.

III. Acknowledgement of Receipt of Privacy Practices

The patient writes their name on the line to show our privacy practices have been received in regards to how their health information will be disclosed and protected which is required by HIPPA regulations.

IV. Consent and Authorization

The patient signs this agreement authorizing and consenting to medical treatment by BCFM staff. Patients will have any procedures/treatments explained to them and can consent or refuse any treatments/procedures. It also states no experimental procedures will be performed without full knowledge or consent given by the patient.

The financial agreement allows for BCFM to bill insurance for any procedures/treatments done at time of service. The patient is agreeing to pay for any portion of the bill not paid for by insurance. Patient is also agreeing for BCFM to furnish information to other providers of service for billing and insurance purposes. If a cell phone number is given to us, the patient is granting BCFM, and our agents and contractors, consent to receive calls on their cell phones in regards to billing and debt collection purposes.