Gerizim, PLLC
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Health Insurance Portability & Accountability Act (HIPAA)
Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Gerizim, PLLC for the purpose of diagnosing or providing treatment to me, obtaining payment of my health bills or to conduct health care operations of Gerizim, PLLC.

I understand that diagnosis or treatment of me by Gerizim, PLLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. Gerizim, PLLC is not required to agree to the restrictions that I may request. However, if Gerizim, PLLC agrees to a restriction that I request, the restriction is binding with Gerizim, PLLC.

I understand Gerizim, PLLC uses a variety of electronic communication methods including phone, text messages, email, etc. to communicate with me for the limited purposes appointments, available services, and other healthcare related communications. I authorize Gerizim, PLLC to disclose limited protected health information to other persons who may answer my electronic communications such as phone, text messages, or e-mail. These may include information about appointments, available services, or other healthcare related communications.

I understand my treatment may require psychiatric consults conducted over a video teleconference service. I authorize Gerizim, PLLC to disclose protected health information to such services for the purposes of conducting such consults.

I have the right to revoke this consent, in writing, at any time, except to the extent Gerizim, PLLC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Gerizim, PLLC's Notice of Privacy Practices before signing this document.

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Initials

Upon request, a copy of the Gerizim, PLLC's Notice of Privacy Practices is available to me. The Notice of Privacy Practices is available in the reception area and on the Gerizim, PLLC web site at https://gerizimpllc.com.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Gerizim, PLLC. The Notice of Privacy Practices also describes my rights and the duties of Gerizim, PLLC with respect to my protected health information.

Gerizim, PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing Gerizim, PLLC's website, calling the Gerizim, PLLC office and requesting a revised copy be sent in the mail or requesting a revised copy at my next appointment.

_____ Date: _____

Signature of Client or Personal Representative

_____

Name of Client or Personal Representative

_____

Description of Personal Representative's Authority