Ozark Regional VEIN CENTER

Universal Consent Form

HIPPA Consent

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect. The Health Insurance Portability and Protection Act (HIPPA) requires that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe. The Ozark Regional Vein Center (ORVC) 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 consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

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 HIPPA we are not allowed to give this information to anyone without the patient's consent. This consent form will allow ORVC to release your medical and billing information to family members listed in your chart.

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of ORVC to leave messages for patients. The purposes of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss ultrasound or procedure results, or to ask a patient to call regarding an issue or concern. At no time will a representative discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

Authorization to Release Health Information

As needed, we may request relevant medical records from any of your existing healthcare providers that may assist us in your evaluation and treatment.

Photography Consent

I understand that photographs or other digital other images may be recorded to document my care. I agree to have photographs taken for my records, medical purposes, and insurance purposes. I understand that ORVC will retain the ownership rights to these photographs or digital images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy. I waive all my rights to any claims for payment or royalties.

☐ Please check here if you agree to all of the above consents ☐ Please check here if you refuse any of the above consents

If you refuse, please list here: ____

You have the right to revoke any of these consents, in writing, except where we have already made disclosures in reliance on your prior consent.

Print Name: ____ **Date**: ________________

Signature: ____**Date of Birth**: ______________________

Ozark Regional Vein Center
5507 Walsh Lane, Suite 101
Rogers, AR 72758

Tel: 479-464-VEIN (8346)
Fax: 479-464-9046
www.OzarkRegionalVeinCenter.com