

Christina P Lynn, MD

3612 Landmark Drive, Columbia, SC 29204

Phone: (803) 606-6070

Fax: (803) 782-1420

PATIENT HEALTH INFORMATION AND CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested (PHI) to the Health Insurance Company (or companies) provided to us by the patient for the purpose of patient reimbursement. Be assured that this office will limit the release of all (PHI) to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their (PHI). Our office is not obligated to agree to these restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.
8. The patient may be sent newsletters, and other mailings pertaining to our office.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient Signature

Date/Time

I have read and understand how my Patient Health Information will be used and I disagree to these policies and procedures. Physician can decline treatment at this time.

Patient Signature

Date/Time