HIPAA

Patient Privacy Data Release & Consent Form

HIPAA, the Health Insurance Portability and Accountability Act requires that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information and privacy data is secured. The **Delaware Center for Maternal and Fetal Medicine of Christiana Care (DCMFMCC)** requests that each patient sign this patient privacy data release and consent form which allows us to share your protected health information (PHI) or electronic protected health information (ePHI) with other medical service providers and specialists. In addition, this Consent Form is your written authorization permitting DCMFMCC to use and disclose your PHI or ePHI for research purposes, fundraising, issuance of marketing communications, or sale of PHI or ePHI in the event that DCMFMCC is acquired by a 3rd party. You must "OPT-Out" if you do not want your PHI or ePHI used or disclosed as described above.

I choose to "OPT-Out" of the following: _____.

Many of our patients allow family members such as their spouse, parents or others to call and request information including appointment days and times, results of tests and results of procedures. Under the requirements for HIPAA, we are not allowed to give this information to anyone without the patient's written consent. If you wish to have your protected health information released to family members you must review, fill-in, and sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent will remain in force until revoked or requested in writing by you our patient.

I authorize the **Delaware Center for Maternal and Fetal Medicine of Christiana Care** to release information about my care including appointment days/times, results of tests and procedures and billing information to the following individuals:

1. _____Relation to Patient: _____

2. _____Relation to Patient: _____

3. _____Relation to Patient: _____

Patient: _____ Date:_____

Signature of Patient/Guardian: _____

Preferred Method of Communication

Please select your primary and secondary means of communication you prefer for all personal healthcare communications with DCMFMCC:

Primary:_____

Secondary:_____

Insert: Home Phone & #, Cell Phone & #, E-mail Address, Mailing Address, other. Note e-mails will not contain PHI or ePHI in clear-text within transmitted e-mails from DCMFM.

Authorization to Leave Messages with Household Members/Answering Machine

From time to time it is necessary for representatives of the **Delaware Center for Maternal and Fetal Medicine of Christiana Care** to leave telephone 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 lab, pathology or procedure results, or to ask a patient to call our office regarding an issue or concern.

At no time will a representative of the **Delaware Center for Maternal and Fetal Medicine of Christiana Care** 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. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent will remain in force until revoked.

DCMFMCC may leave messages on my home phone number_____ or cell phone number _____voice messaging system.

DCMFMCC may leave the message with a family member listed on this form: Yes or No

Patient: _____ Date:_____

Signature of Patient/Guardian: _____

Receipt & Acknowledgment of DCMFM's Patient Privacy Data Release & Consent Form

By signing and dating here, you acknowledge receipt of the DCMFM Patient Privacy Data Release & Consent Form and have reviewed these practices and procedures and fully understand them. It is your right to request a hardcopy from DCMFM or you may download a copy of this document here www.dcmfm.com/forms/.

Patient: _____ Date:_____

Signature of Patient/Guardian: _____