Sylvia A. Gisi, M.D.
FAMILY PRACTICE
31493 Rancho Pueblo, Suite 204, Temecula CA 92592
Phone: 951-303-6158 Fax: 951-303-8492

HIPAA Compliance Patient Consent

Patient Name: _____ Date: _____

Under the Health Insurance Portability and Accountability Act of 1994("HIPAA"), The Family Practice of Dr. Sylvia A. Gisi does not release confidential medical information regarding your treatment to family members or friends, except for a parent/legal guardian or other persons authorized by the patient.

Exceptions Caused by Circumstances:

If you bring another person into the exam room during a regular or emergency appointment, we will assume without objection, the person(s) is entitled to hear or receive information regarding your medical issue and/or treatment.

Notice of Privacy Practice:

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

Contact Authorization:

I, _____, hereby give my consent to Dr. Gisi and her staff to contact me regarding labs, x-rays, referrals, and appointments via:

(Select all the apply)

☐ Email: _____

☐ Cell Phone: (_____)_____ ☐ Cell Phone Voicemail

☐ Home Phone: (_____)_____ ☐ Home Phone Voicemail

☐ Spouse/Significant Other Name: _____

☐ Parent / Legal Guardian Name: _____ Phone: (_____)_____

☐ Emergency Contact Name: _____ Phone: (_____)_____

☐ Mail: Address: _____ City/State/Zip: _____

☐ **DO NOT CONTACT ANYONE OTHER THAN ME PERSONALLY.**

Sylvia A. Gisi, M.D.
FAMILY PRACTICE
31493 Rancho Pueblo, Suite 204, Temecula CA 92592
Phone: 951-303-6158 Fax: 951-303-8492

HIPAA Compliance Patient Consent

Prescriptions/Records Release:

If you need to pick up a prescription or require your medical records released to another person other than yourself, please list them below.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

In case of Emergency, who should be notified? Name: _____

Relationship to Patient: _____ Contact Phone #: _____

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Any changes to this form must be made in person at the Family Practice of Dr. Sylvia A. Gisi.

_____ _____ _____
Patient Name: Date: Received By:

_____ _____
Patient Signature or Patient Representative Relationship (If Signed by Other than Patient)