Dr. Pretlow Stevenson, Jr.
3412 Columbia Street
Portsmouth, VA 23707
Phone: (757)397-5611
Fax: (757)397-5573

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that IDr. Pretlow Stevenson, Jr. may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Dr. Pretlow Stevenson, Jr. has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Dr. Pretlow Stevenson, Jr. will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Dr. Pretlow Stevenson, Jr. to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Dr. Pretlow Stevenson, Jr. has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Dr. Pretlow Stevenson, 3412 Columbia Street, Portsmouth, VA 23707, (757)397-5611.

FORM Us

PATIENT AUTHORIZATION FORM

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed:

_____

_____

_____

_____

_____

Person or entity requesting the information and authorized to make the requested use or disclosure:

_____

Recipient of the information: _____

This information is being requested for the following purpose(s):

_____

_____

_____

_____

_____

This authorization shall remain in effect from the date signed below until

_____ (expiration date or event)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

☐ If this box is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient Name: _____ Signature: _____

Relationship to Patient

(if signed by personal representative of Patient): _____ Date: _____