CLIENT AUTHORIZATION FOR USE & DISCLOSURE OF PHI

Sacramento LGBT Community Center provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which provides safeguards to protect your privacy. HIPAA provides certain rights and protections to you as the Client/Patient. Restrictions of this authorization do not include the typical interchange of information within our office necessary to provide you with services in our offices.
Please review this form in its entirety before signing. You do not have to sign this authorization and disclosure.

1. Client information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes sharing information with other healthcare providers, laboratories, and health insurance payers as necessary and appropriate for your care. The normal course of providing care means that such records may be left temporarily in administrative areas. Those records will not be available to persons other than Health Services staff.

2. You agree to the standard procedures utilized within the office for handling charts, Client records, PHI, and other documents or information.

3. It is the policy of this office to remind Clients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means as requested by you. In addition, we may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

4. The Center utilizes several vendors in the conduct of business. These vendors may have access to PHI but are required to abide by the confidentiality rules of HIPAA.

5. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in the typical performance of their duties.

6. You agree to bring any concerns or complaints regarding privacy to the attention of the clinic director or the doctor.

7. Your confidential information will not be used for marketing or advertising products, goods, or services.

8. We agree to provide the Client with access to their records in accordance with State and federal laws. We may change, add, delete, or modify any of these provisions to serve better the practice's and the Client/patient's needs.

9. You have the right to request restrictions in using your protected health information and to request change.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment and health care operations. You have the right to revoke this Consent in writing.

_____ Patient Signature _____Date

_____ Center Staff Signature _____Date