Summit Psychiatry HiPPA Consent

Authorization for Use and Disclosure of Protected Health Information

Patient Name ____

Date of Birth ____

Phone Number ____

Email ____

Summit Psychiatry is committed to protecting your privacy and maintaining the confidentiality of your protected health information (PHI). Under the Health Insurance Portability and Accountability Act (HIPAA), we require your authorization to use or disclose your PHI for treatment, payment, and healthcare operations.

1. Purpose of This Consent By signing this form, I authorize Summit Psychiatry to use and disclose my PHI for:

• Coordination of my treatment, including communication with other healthcare providers.

• Billing and payment purposes, including insurance claims processing.

• Internal healthcare operations, including quality assessment and compliance activities.

• Communication with individuals I designate to be involved in my care.

2. Authorized Individuals or Entities I authorize Summit Psychiatry to release my PHI to: Healthcare providers or organizations (list names and purpose):

____

Insurance providers for billing purposes

____

Family members or others involved in my care (list names and relationship):

____

3. Patient Rights I understand that:

• I have the right to revoke this authorization at any time by providing a written request to Summit Psychiatry.

• Revocation does not apply to information already disclosed in reliance on this authorization.

• My treatment, payment, or eligibility for benefits is not conditioned on my signing this authorization.

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• There is a possibility that information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by HIPAA regulations.

4. Duration of Consent This authorization will remain in effect indefinitely unless I revoke it in writing.

5. Consent to Communication I authorize Summit Psychiatry to communicate with me using the following methods (check all that apply):

☐ Voicemail

☐ Email

☐ Text Message

6. Acknowledgment and Signature By signing below, I acknowledge that I have read and understand this form. I voluntarily authorize the use and disclosure of my PHI as stated above.

☐ By checking this box, I agree to use electronic records and signatures and I acknowledge that I have read the related consumer disclosure.

Patient Name and DOB: ____

____ ________________

Patient or Guardian Signature Date