HIPAA DISCLOSURE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. Protected Health Information (PHI) may originate in your medical record at IKP, or may be received from outside health entities and filed in your medical record. I understand that this information can and will be used by IKP to: (a) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly (b) Obtain payment from third-party payers (c) Conduct normal healthcare operations such as quality assessments and physician certifications (d) Notification of educational events specific to my
medical condition through **IKP** or networking organizations.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices from my local office or by contacting the Privacy Officer at 1300 W. Terrell, Suite 405 Fort Worth, TX 76104. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature:____**Date:**_____________________
Patient/Guardian

RELEASE OF INFORMATION AUTHORIZATION

____**IKP may or may not** mail lab results to me
____**IKP may or may not** release medical records to other requesting physicians.
____**IKP may not** discuss my healthcare and may not discuss and/or make financial arrangements with anyone.
____**IKP may** discuss my healthcare and **may** discuss and/or make financial arrangements with any immediate family member.
____**IKP may** discuss my healthcare and **may** discuss and/or make financial arrangements with only the following individual's listed below:

Name ____**Relationship**_________________

Name ____**Relationship**_________________

Name ____**Relationship**_________________

PREFERENCES

I prefer to be contacted in the following manner:

Phone#: (   ) _______________________
____Leave message with detailed information.
____Leave message with contact number only.
____ Do Not leave message.

Phone#: (   ) _______________________
____Leave message with detailed information.
____Leave message with contact number only.
____ Do Not leave message.

EMAIL:____

Signature:____**Date:**________________________
Patient/Guardian