Ernest Savransky, M.D., LLC

Ernest Savransky, M.D., FASN

Nephrology & Hypertension

PATIENT HIPPA CONCENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Authorize the release of any requested medical records about me to Ernest Savransky, M.D., LLC for diagnostic and treatment purposes;

Authorize diagnostic procedures and medical treatment by Ernest Savransky, M.D., LLC;

Authorize release of any requested medical records about me for claims and billing purposes to Ernest Savransky, M.D., LLC;

Authorize direct payments to Ernest Savransky, M.D., LLC.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protective health information is used and disclosed to carry out treatment, payment and healthcare, operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosures that occurred prior to the date I revoke this consent is not affected.

Patient Name_____

Signature_____

Date_____

Relationship to Patient: Self

Other_____