**HIPAA SUMMARY**

In the course of receiving services from Compass Medical Clinic, you will provide us with personal information about your health with the understanding that this information will confidentially be used solely for your benefit.

The intention of HIPAA is to maintain the privacy of your health information. Your information is used to contact you, order medications, bill insurance, and coordinate care to name a few things. We **will not** share your information with anyone whom you do not authorize.

Your rights include:

1. Decide who you authorize to receive your health information

2. Request restrictions on how your information is shared

3. Request confidential communication by a specified means

4. Inspect and receive a copy of your health information

5. Request us to amend your chart if you feel there is an error

6. Request a list of the log of releases we’ve made of your information

7. Receive a paper copy of this notice

8. Complain about our Privacy Practices

By signing below, you acknowledge your understanding of HIPAA and our compliance with the laws protecting your information. You have been provided with a full copy of HIPAA with this short form and may read it prior to signing below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Signature Date

**AUTHORIZATION TO RELEASE PROTECT HEALTH INFORMATION**

I authorize Compass Medical Clinic to release information to:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_