



LAST NAME

FIRST NAME

MEDICAL RECORD NUMBER

HIPAA Privacy Notice

In accordance with the Health Insurance Portability and Accountability Act of 1996, patients of this practice are entitled to the greatest degree of privacy possible. This office will strive to ensure that patient information is used only for authorized purposes as agreed to by the patient.

Patients are advised that they have a right to review their medical files upon reasonable notice to the practice and during normal business hours, and to make comments to the same. Patients have the right to direct the methods of communication of their medical information and to specify the individuals to whom they wish their medical information released to, in addition to those indicated on the “consent to release medical information” form.

Practice Policies and Procedures

- Before any records are released, staff will review to ensure that only the information necessary has been released.
- Before any records are released, staff will review to ensure that the release has been authorized by the patient or is otherwise permitted by law.
- Except in emergencies or as required by law, the patient (or the patient’s agent) shall be notified before any records are released.
- Sign-in sheets used in the waiting room will not contain any medical information / reason for patient’s visit.
- Only licensed health care professional members of the staff shall have access to medical records. Other staff members shall have access limited to portions of the records directly related to their duties (for example, the secretary shall have access to the pharmacy records for the purpose of refilling prescriptions).
- At the close of business each day, all medical information shall be secured in a protected area marked confidential or in the physician’s office.
- Each patient chart shall include records of all releases of information, including the date, to whom the information was sent, and the material included.
- Oral PHI (Protected Health Information) should not be communicated in general patient areas. Except in emergencies, all discussions regarding patient care shall be conducted either in that patient’s examination room or in the physician’s private office.

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Diplomate in Endocrinology, Diabetes and Metabolism
Diplomate in Internal Medicine



- Oral PHI should not involve unnecessary parities. Discussions concerning patients should never be made in another patient’s examination room.
- Common area conversations concerning patients are to be avoided.
- Out-of-office conversations regarding PHI are forbidden.
- Parents and Minors
Only the parent or legal guardian of a child has the right to access records.
 - Exceptions include:
 - State law pre-emption (e.g., applicable state law concerning pregnancy or sexually transmitted diseases).
 - Court order.
 - Potential abuse or neglect.
 - With parent or guardian consent.

Receipt of Privacy Notice

By signing below, I confirm that I have received and read the privacy notice given to me in accordance to HIPPA.

Signature: _____ **Date:** _____

If person other than patient is signing, please print full name and indicate relationship below.

Print Full Name

Relationship to Patient

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Consent Form for Medical Information Disclosures

Patient Name: _____

In connection with the medical services that I am receiving from the above-named physician / provider, I hereby authorize that above-named physician / provider to disclose any / or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to:

- A. Any third party payor covering the medical services of the patient;
- B. Other health care professionals and institutions involved in the delivery of health care to the patient;
- C. The proponent of any legally sufficient subpoena, or in response to a court order;
- D. Employees and agents of the practice, to the degree necessary to facilitate the provision of health care services and payment for such services;
- E. Pharmacies; and
- F. Other parties as otherwise required by law.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given a copy of the physician's privacy notice and that I have had the opportunity to place special restrictions upon the consent hereby given.

Special Restrictions:

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Patient Name: _____

I am consenting to receive my medical information by the following communication method:

Please check all that apply

- telephone conversation
- telephone message on my home answering machine
- telephone message on my cell phone
- telephone message on my office voicemail
- leave telephone message with: (name of individuals who are authorized to receive your medical information by phone)

I consent to have my medical information discussed with:

Please check all that apply and include name

- spouse: _____
- parents: _____
- children: _____
- other: _____

This consent is valid from the date executed until revoked in writing by the patient.

Signed: _____ Date: _____

Witness: _____ Date: _____

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