KARIN C. LI, MD – INTERNAL MEDICINE (English) KLI #2 (rev 1/2012)

Date _____

Patient Authorization/Health Insurance Portability and Accountability Act (HIPPA)

1. Please print the telephone numbers where you want to receive calls or information about your appointments, labs, or other health care issues that would come directly from our physicians or staff.

Home Phone_____ Cell Ph_____

Work Ph_____ Email_____

2. Can confidential messages (e.g. appts, labs, referrals, medical reports) be left on your home answering machine, cell phone voicemail or email? □Yes □No

3. Please list the family members or other persons whom we can inform about your general medical condition and/or diagnoses.

Name(s)/Relationship(s)_____

The information on this authorization is applicable for 1 year from the date this form is signed and agreed upon by the patient. After the 1 year period, this information will be automatically effective for consecutive 1 year periods UNLESS patient informs us to change the information above.

Patient Name_____ Signature_____ **Date**_____

Patient Acknowledgement of Healthcare Information Privacy

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; Obtain payment from third party payers; Conduct normal healthcare operations such as quality assessments and physician certifications.

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 have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may cause this organization at any time at the address of record to obtain a current copy of the Notice of Privacy Practices.

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 that 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 acknowledgement in writing at any time, except to the extent that you have taken action relying on this acknowledgement.

Patient Name_____ Signature_____ **Date**_____

Authorized Rep._____

*****TWO-SIDED FORM (Complete Other Side)*****