ARIZONA CENTER FOR
Hand to Shoulder Surgery

Hand to Shoulder Surgery & Reconstructive Microsurgery • www.achssurgeons.com
Phone (602) 258-4788 • Fax (602) 258-5131

HIPAA Consent Form

Please read this form carefully **as ACHS will only speak to the person you name below in regard to the Health, Billing or Scheduling Information we collect about you.** Keep in mind that if you check "I elect not to give consent" we will not speak to anyone, including family members, friends, and attorneys etc. who call for information. **Remember that under the HIPAA Privacy Rule and as outlined in our Notice of Privacy Form, we do have the right to disclose medical information to certain individuals to aid in your continuity of care.**

Patient's Name: _____

Patient's Account Number: _____ **Patient's Date of Birth:** _____

□ I give the following individual (s) my consent to call or act on my behalf. This consent is restricted to the options I have selected. If at any time I wish to change the individual (s) listed below, I am aware that I must notify the office in writing (i.e., complete a new consent form)

This consent is valid until we are notified by the patient of a change

Name: _____ **Relationship** _____

Address: _____

Phone: _____ **Alt Phone:** _____

Please mark only one box

□ All Information (Billing, Scheduling Appointments and Treatment Information)
□ Only Billing Information
□ Only Scheduling Appointments
□ Other (Please be Specific): _____

Name: _____ **Relationship** _____

Address: _____

Phone: _____ **Alt Phone:** _____

Please mark only one box

□ All Information (Billing, Scheduling Appointments and Treatment Information)
□ Only Billing Information
□ Only Scheduling Appointments
□ Other (please be specific): _____

□ I elect not to give consent for any other individual (s) to call or act on my behalf. Any information pertaining to my treatment, billing or other information should only be disclosed to me. If at any time, I wish to add individual (s) to call or act on my behalf, I am aware that I must notify the office in writing (i.e., complete a new consent form)

Patient Signature: _____ Date: _____