Culpeper Medical Clinic
Walk-in & Primary Care

451 James Madison Hwy, #104
Culpeper, VA 22701
Phone: (540) 727-8880
Fax: (540) 727-8882

HIPAA Privacy Act Patient Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) requires that all medical providers, insurance companies, and other medical facilities put in place controls to ensure that your personal medical information is safe. Our office requests that each patient signs this consent form which allows us to share protected health information with other physician offices, hospitals, and insurance companies. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notices before signing this consent.

Patient Name (Print): _____ **DOB:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Alternate Phone:** _____

Email Address: _____

It may be necessary for our office to leave messages for patients for the purposes of appointment reminders, reviewing insurance benefits, notification of lab and procedure results, or to further discuss any issues or concerns. At no time will our office discuss your medical circumstances or condition without your consent. The purpose of this agreement is to allow our office to leave messages with members of your household.

Please indicate any individuals you authorize to have access to your protected health information in the spaces provided below:

1) Name: _____ **Relation:** _____ **Phone:** _____

2) Name: _____ **Relation:** _____ **Phone:** _____

This agreement is valid for one (1) year from the date of signing, and must be updated to reflect changes to patient information. I affirm that the information I have provided above is true to the best of my knowledge.

Patient Signature: _____ **Date:** _____