KS Fitness + Co, LLC

HIPAA CONSENT FORM
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

TO OUR PATIENTS:

Patient information will be maintained by KS Fitness + Co as described by the Notice of Privacy Practices contained in the Corporate Compliance Program and in compliance with federal and state regulation. You may obtain a copy of the Notice of Privacy Practices by contacting the Office Manager.

KS Fitness + Co reserves the right to release your healthcare information based upon a decision by your physician for medical emergency situations and in general for continuity of care. We will release your healthcare information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone else that you may elect in writing to receive it. We will release information related to any work related injury to your employer. For continuity and quality of care, we may also receive information regarding your prescriptions from your pharmacy.

We reserve the right to:

- Call you to remind you of your next appointment and/or leave information on your answering machine.

- Call you with lab and/or test results and leave information on your answering machine.

  At what number(s) would you like to be contacted? _____-_____-_____

If we cannot contact you at the above number(s), numbers from the information sheet will be used.

- Contact you for potential research that might benefit your well-being.

If there is anyone that you would like us to share your health information with, please list the names below:

_____

_____
____

I have read and understand my rights.

_____ _____ _____
Signature of patient or legal guardian Date Signature of KS Fitness + Co witness

_____ _____
Print the name of the patient DOB/Acct #

Consent for Communication

Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. KS Fitness + Co, LLC respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. As well voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text. KS Fitness + Co, LLC will not be responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

- ☐ I do not consent to any voicemail, email or texting communication.
- ☐ I consent to receiving communication about the scheduling of appointments or other communications that do not reveal my protected health information only by the following means (check all that you consent to):
  - Email
  - Text
  - Voicemail
- ☐ I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means (check all that you consent to):
  - Email
  - Text
  - Voicemail

E-mail address you are consenting to communicate through: _____

Phone number you are consenting to communicate through:_____

Patient Signature: _____ Date_____

Authorized Representative/Guardian Signature:_____ Date_____