HIPAA CONSENT

PATIENT NAME (Print): _____ **DOB:** _____

Family Care Associates of Blair County
DBA Quantum HealthCare Services LLC
125 Carson Valley Road
Duncansville, PA 16635

I, _____, understand and acknowledge that FCA is committed to safeguarding the privacy and security of my protected health information (PHI) as required by the Health Insurance Portability and Accountability Act (HIPAA) and its associated regulations.

1. Authorization for Use and Disclosure of PHI: I authorize FCA to use and disclose my PHI for the purpose of treatment, payment, and healthcare operations. This includes but is not limited to sharing information with other healthcare providers involved in my care, insurance companies for claims processing, and necessary administrative and billing purposes.
2. Rights Regarding My PHI: I understand that I have the right to:
    a. Request restrictions on certain uses and disclosures of my PHI, although FCA may not be obligated to comply with such requests.
    b. Access, inspect, and obtain copies of my medical records, subject to legal limitations and any associated fees.
    c. Request amendments or corrections to my medical records if I believe they are inaccurate or incomplete.
    d. Receive an accounting of disclosures made of my PHI by FCA for purposes other than treatment, payment, or healthcare operations.
    e. Request confidential communications, such as alternative methods or locations, to receive communications of my PHI.
3. Authorization Revocation: I understand that I have the right to revoke this HIPAA consent at any time. However, such revocation will not affect any actions taken by FCA prior to receiving the revocation.
4. Acknowledgment of Privacy Notice: I have received a copy of the Notice of Privacy Practices from FCA, which explains in detail how my PHI may be used and disclosed and outlines my rights as a patient under HIPAA.

I acknowledge that I have read and understood the above information and voluntarily provide my consent for FCA to use and disclose my PHI as outlined in this HIPAA Consent Form.

Patient Signature: _____ Today's Date: _____

Representative Name (Print): _____ Relationship: _____