WILLOW BEND FAMILY MEDICINE, P.A. 6124 WEST PARKER ROAD, STE. 138 PLANO, TX 75093
(972) 981-7000 / (972) 981-7001 fax

NOTICE OF PRIVACY PRACTICES

It is the policy of Willow Bend Family Medicine, P.A. to release personal information only to individuals who have been authorized by the patient or a legal guardian to receive such information. Willow Bend Family Medicine has a legal, ethical and moral obligation to protect your personal Health Information (HIPAA). Any information about you or your family will be held in the strictest of confidence by all employees. No discussions about you outside of the patient care framework will be allowed, and any conversation between staff members that pertains to delivering you quality care will be held in a confidential and professional manner. **This consent shall self terminate two years following my death or I may revoke my consent in writing at any time. Specifically, we will need to disclose your private information under the following circumstances:**

> **Sharing Information for purposes of treatment, payment, and operation: Willow Bend Family Medicine, P.A. will share all necessary information with other professional providers, insurer(s), payor(s), governmental entities (such as Medicare, etc.) and their representative (including, but not limited to benefit determination and utilization review) as well as our representatives involved in the billing process (including, but not limited to claims representatives, data warehouses, billing companies, and collection agencies).**

I understand that by signing this form I consent to the above. Should I decide to revoke my consent any disclosure given in reliance on the prior consent will be permissible. Please notify the office if you ever decide to revoke your consent.

_____ _____
Patient's Name (print) **DOB**

_____ _____
Patient's Signature (or guardian, if minor) **Date**

RELEASE OF PRIVATE HEALTH INFORMATION

I authorize the release of my confidential protected health information to family or friends listed below. Including all medical records from past, present and future medical care or mental health condition, including all information relating to diagnosis, laboratory testing and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

_____	_____	_____
FAMILY MEMBER/ FRIENDS NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
FAMILY MEMBER / FRIENDS NAME	RELATIONSHIP	PHONE NUMBER