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The Department of Health and Human Services has recently enacted the HIPAA (Health Insurance Portability and Accountability Act) privacy rule to protect patient privacy. The rule requires physicians and hospitals to take necessary precautions to limit how much protected health information about a patient can be disclosed and to whom. It also requires an enactment of a privacy policy and notification of the policy to each patient.

We are required by law to obtain your signature indicating that we have informed you of our HIPAA Privacy Policy.

Specific Consent for Drs. Kossow, Brown and Rehor:

I hereby authorize any agent of Drs. Kossow, Brown and Rehor to make appointments at their office or with consultants to whom they may make referral or from whom they may make referral or from whom they may request consultation for me or for the patient for whom I am the responsible or authorized party. Furthermore, I authorize any agent of Drs. Kossow, Brown and Rehor to examine, diagnose and treat, to perform laboratory tests or diagnostic tests, to administer medications and immunizations, to write, fax, telephone or electronically transmit prescriptions, and to disclose information as necessary to me, my designate and medical, educational, or ancillary medical consultants on behalf of the patient(s) named herein, when Drs. Kossow, Brown and Rehor believe such action is in the best interest of the patient.

I have been given the opportunity to review the Privacy Policy Statement of Drs. Kossow, Brown and Rehor. I understand that I may revoke or amend this authorization at any time or request to restrict the disclosure of the personal health or financial information as set forth herein.

This authorization will expire when the patient is no longer under the active care of Drs. Kossow, Brown and Rehor or the patient's association with Drs. Kossow, Brown and Rehor has been explicitly terminated.

Please initial below all that apply:

I give Drs. Kossow, Brown and Rehor permission to leave clinical information on the following answering devices. ***Please initial on which device we can leave clinical information***:

_____home _____cell _____work

I give Drs. Kossow, Brown and Rehor permission to discuss clinical information about myself (or the patient for whom I am the responsible party) with the following people ***(family members or close friends***):

_____

_____

_____

_____

_____ _____

Patient's Printed Name Authorized signature

_____ _____

Date Relationship to patient – *if patient not signing*