SCH Professional Corporation

I, _____ _____

(Name: First & Last) **Date of Birth**

The HIPAA Privacy Act was passed to protect your rights to privacy concerning your medical information. Federal law requires that we have your signature on file in your chart instructing us as to how to handle your medical information. Include the names of any family members, family doctor or other medical personnel that you permit to be informed of your medical information. Do not assume that our staff knows whom we can speak to regarding your medical information.

Authorize SCH Professional Corporation to provide my medical information to:

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_____

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Privacy Practices

I hereby acknowledge that I received the Notice of Privacy Practice of SCH Professional Corporation which sets forth the ways in which my personal health information may be used or disclosed by SCH Professional Corporation, and outlines my rights with respect to such information.

Social Media Communication

Understand and acknowledge that any communication to SCH Professional Corporation Physicians, Nurse Practitioners, Physician Assistants, or office staff members initiated through unapproved media or communication platforms, such as Facebook, Twitter, Instagram, and personal home phone or personal cellphone calls or texts will not be acknowledged and will not receive a response. Timely answers to non-urgent issues and questions will be provided through FollowMyHealth Patient Portal Messages, in person, onsite encounters, and physician office phone messages. If you are having an emergency, call 911 or go to your nearest emergency room.

Consent For Treatment

I consent to the appropriate treatment for the patient's condition. I hereby authorize direct payment of surgical/medical benefits for services rendered by the physicians of SCH Professional Corporation in person or under his/her supervision. I understand that I am financially responsible for my health insurance deductibles, co-insurance and any other charges not paid by my insurance and that payment is due at the time service is rendered. I authorize SCH Professional Corporation to release any medical information that may be necessary for either medical care or in processing applications for financial benefit.

Above authorizations expire one year from date of signature.

Signature below pertains to each of the 4 sections above.

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Signature (Parent or guardian if a minor) **Date**