CAPE MEDICAL GROUP

PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Privacy Practices Acknowledgement of Notification

The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Cape Medical Group may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, we will post the changes in all offices.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

By signing below, you acknowledge receipt of our **Notice of Privacy Practices.**

Patient's Signature Date

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to **Cape Medical Group** for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its' agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier agreements.

Patient's Signature Date

Print Full Name DOB

17005 Old Orchard Road, Lewes, DE 19958
302-703-4025 | www.cmgdel.com

CAPE MEDICAL GROUP

PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED INFORMATION TO BE USED AND/OR DISCLOSE (OPTIONAL)

Name or specifically identify these persons and/or entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations.

Name of Authorized Person or Entity	Relationship	Phone #
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AUTHORIZATION FOR USE OF USPS MAIL, ANSWERING MACHINE, VOICEMAIL AND/OR PATIENT PORTAL

Cape Medical Group physicians and healthcare staff routinely are unable to contact patients directly during normal business hours. On these occasions our offices leave messages on communication devices provided by our patients. Due to the new federally mandated HIPAA Privacy Rule we must obtain your authorization to continue this mode of communication.
Protected Healthcare Information that we may possibly disclose on your home, work, mobile phone, patient portal account, and current home address on file would include, but is not limited to: test/lab results, prescription/pharmacy information, patient plans, future orders, appointment instructions for visits and procedures, and clinical information.

____(Initial) I agree to allow **Cape Medical Group** physicians and healthcare staff to leave messages that include Protected Healthcare Information of the following: Please initial next to the applicable communication devices:

___home number ____work number _____mobile number _____Patient Portal ____USPS Mail

____(Initial) No, I do not agree to allow **Cape Medical Group** physicians and healthcare staff to leave messages that include Protected Healthcare Information on my home, work and cell phone.

Patient's Signature Date

For CMG Internal Use Only

UNABLE TO OBTAIN NOTICE RECEIPT ACKNOWLEDGEMENT

Option 1: I could not obtain a signed Notice Receipt Acknowledgement from the patient for the following reason: _____

Option 2: I attempted to obtain a signed Notice Receipt Acknowledgement from the patient on _____/_____/_____, but was unable for the following reason: _____

CMG Employee Signature Date