Omni Therapy Solutions
Speech·Occupational·Physical
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CONSENT TO COMPLY WITH FEDERAL HIPAA ACT
Patient Consent for Use and Disclosure of Protected Health Information

With my consent and signature, Omni Therapy Solutions (OTS) may use and disclose protected health information about me or my child to:

1. Carry out treatment, payment, and healthcare operations (services).
2. Call my home or other designated locations and leave a message on voice mail in reference to any items (i.e. appointment reminders, insurance items, references to clinical care of laboratory results, etc.) that will assist in the practice of medical care for my child or me.
3. Mail to my home or other designated address any item (i.e. appointment reminder cards, patient financial statements, etc.) that will assist in the practice of medical care for my child or me. Such correspondence is to be marked personal and confidential.
4. Send or transmit email to any location provided by me for all the above similar items and purposes.
5. To use and/or disclose protected health information about me or my child to/with third parties involved in mine or my child's care. Such parties may include, but are not limited to, insurance companies, hospitals, specialty physicians, and laboratory personnel. I may specifically describe the type of information (i.e., dates of services, level of detail, origin of information, etc.) subject to disclosure and may revoke this permission at a time and date chosen by me. By providing a written statement to the privacy office of OTS, I may revoke this permission; however, OTS may decline to provide further treatment to my child or me. OTS may also decline further treatment to me or my child should my restrictions on the type of third-party information, in the center's opinion, impede the medical care of my child or me.

I have the right to request that OTS restrict how it uses or discloses my or my child's health information. However, as stated previously, OTS is not required to agree to my restrictions. If OTS accepts my restrictions, OTS is then bound by the restriction in the agreement, setting forth the restricted information until providing me, in writing, a cessation of such agreement.

I may revoke this entire consent, in writing, at any time. If I do not sign this consent or revoke this consent, OTS, in its sole discretion, may decline further treatment for me or my child.

The Federal HIPPA (Privacy Act) of 2001 was created to protect my child's and my health information. I understand this must be accomplished within the provisions and rules set up by OTS to fulfill federal law. I may request to review the manual which spells out these provisions. OTS will comply with this law to preserve privacy. If compliance with this law impedes the medical care of the patient, OTS may decline to provide further care. OTS will strive to provide information so that I may make an informed decision concerning the privacy of my or my child's medical information.

Uses and Disclosures without Authorization:
We may use or disclose PHI without your consent or authorization in the following circumstances: • Child Abuse - If we have reason to believe that a child has been subjected to abuse or neglect, we must report this belief to the appropriate authorities. • Adult and Domestic Abuse -We may disclose protected health information regarding you if we reasonably believe that you are a victim of I abuse, neglect, self-neglect or exploitation. • Health Oversight Activities - If we receive a subpoena from the South Carolina Dept. of Medicaid because they are investigating our practice, we must disclose any PHI requested by the Board. • Judicial and Administrative Proceedings - If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or consent.

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Signature of Patient or Parent/ Legal Guardian of Minor Child

_____ _____ _____
Patient's Name Date of Birth Date of Signature

_____ _____
Printed Name of Signature Above Initials of Witness