

PATIENT CONSENT FORM (HIPAA)

Our notice of privacy practices provides information about how we may use and disclose Protected Health Information, (PHI), about you. The notice contains a Patients Right section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected the PHI about you is used or disclosed for treatment, payment and health care operation. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our policy of PHI. You have the right to revoke this consent signed, in writing, signed by you. However, such revocation shall not affect any disclosures we have made in reliance on your prior consent. We have provided this form to comply with the Health Insurance Portability and Accountability Act of 1996(HIPAA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment or health care operation.
- The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of his / her information but the Practice doesn't have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon the execution of this consent.

The consent was signed by: _____
(Patient's name and patient's or Representative or Guardians Signature)