HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment including referred providers.
- Obtaining payment from third party payers (e.g., my insurance company).
- The day-to-day healthcare operations of our practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected heath information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do not agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, and at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

PLEASE LIST ANY AUTHORIZED PERSON WE MAY SHARE INFORMATION WITH. (E.G., HUSBAND WIFE, DAUGHTER, SON, ETC….)

AUTHORIZED PERSON: _____RELATIONSHIP: _____

AUTHORIZED PERSON: _____RELATIONSHIP: _____

DATE: _____ PATIENT PRINTED NAME: _____

SIGNATURE: _____