

Patient 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 use and disclose my protected health information to carry out:

- Treatment- direct or indirect treatment also by other healthcare providers
- Obtaining payment from third party payers (ex: insurance company)
- The day to day healthcare operations of your 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 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 health information is used and disclosed to carry out treatment, payments, and health care operations, but that you are not required to agree to these requested restrictions. However if you do agree, you are then bond to comply with this restriction.

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

Patient Name: _____ Date: _____

Signature: _____ Relation to patient: _____

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