

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple medical providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers

Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

I understand I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Date: _____

Is there anyone we can discuss your medical conditions with? Yes NO

Name of Party who we can discuss your treatment or medical conditions with: _____ Relationship to Patient: _____

Signature of Patient: _____

Date: _____