

## HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk). You have the right to review our full Notice before signing the 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 protected health information about you that is used or disclosed for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment, and health care operations. You have the right to revoke this consent, in writing, reliance on your prior consent. The practice provides 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 operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The practice reserves the right to change the Notice of Privacy Policy.
- The patient has the right to restrict the use of their information.
- The patient may revoke this Consent in writing, at any time and all future disclosures will then cease.
- The practice may condition treatment upon execution of this consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form; therefore payment in full is required at the time services are rendered.

**Information sharing:** Please list any individuals we can share your person information with other than healthcare providers.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact #: \_\_\_\_\_

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to Patient(if other than patient)