HIPAA Patient Consent Form

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights 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 health information about you is used or disclosed for treatment, payment and health care operations. 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 use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

*Protected health information may be disclosed or used for treatment, payment, or healthcare 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 Practices.
*The patient has the right to restrict the uses of their information, but the Practice does not 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 receipt of treatment upon the execution of this Consent.

The Patient allows the Practice to disclose treatment, payment, or health care information to the following individuals:

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____

I HAVE READ AND UNDERSTANDF THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____ _____
Patient Signature Date

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

_____ _____
Print Name Relationship to Patient