



## 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 multiple Healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operation such as quality assessments and physician 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 at the address below to obtain a correct copy of the **Notice of Privacy Practice**.

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 healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that you 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: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_