

## Patient Consent Form – HIPPA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain right 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 m multiple healthcare providers who may be involved in my treatment, directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certificates.

I have been informed by you of your Notice of Privacy Practices containing a more 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 the address and receive 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 and 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 by such restrictions.

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

Patient name: (print) \_\_\_\_\_

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

Signature: \_\_\_\_\_

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