HIPAA PATIENT CONSENT FORM

The Service Agreement between us provides information about how I may use and disclose protected health information about you. The agreement contains patients' rights describing your rights under the law. You have the right to review our Service Agreement before signing this Consent. The terms of our Service Agreement may change. If we change our Service Agreement, you may obtain a revised copy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or 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 (HIPAA).

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment, or health care operations.
2. The Practice has a Service Agreement and that the patient has the opportunity to review this agreement.
3. The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
4. The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
5. The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by:

_____

Printed Name-Patient or Responsible Party

_____

Patient Signature or Responsible Party Date

_____

Relationship to patient (if other than patient)

Witness: _____

Printed Name-Practice Representative

_____ _____/_____/_____

Signature Date