

HIPAA Compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information, but the practice does not have the right to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this agreement.

May we contact you by phone, text or email to confirm your appointments? Yes No

If no, how: _____

May we leave a message on your answering machine at home or on your cell phone? Yes No

May we discuss your medical conditions with members of your family? Yes No

If yes, please list who may we speak to: _____

This consent is being signed by: (PRINT NAME): _____

Patient/Guardian/POA Signature: _____

Date: _____/_____/_____

Witness: _____

Date: _____/_____/_____