PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- **Treatment** (including direct or indirect treatment by other healthcare providers involved in treatment);
- **Obtaining payment** from third party payers (e.g. insurance companies);
- **Daily healthcare operations** of the practice.

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice, and I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: ______________________________

(Print) Patient Name: ______________________________

Patient or Guardian Signature ______________________________

Relationship to Patient ______________________________

Please list any **additional individuals** whom we may disclose treatment information to or may be responsible for payment (e.g. spouse, grandparent, etc.)

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