

**HIPPA: Patient Consent Form**

Our notice of Privacy Practice provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights Section describing your rights under the law. You have the right to review our Notice before signing this consent as terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you for treatment and health operations. 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 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this consent

Patient wishes to be contacted by:

Cell: \_\_\_\_\_ Email: \_\_\_\_\_

May we leave a message with: Spouse: \_\_\_\_\_ Yes No Other: \_\_\_\_\_

This Consent was signed by: \_\_\_\_\_

Printed Name – Patient or Representative

\_\_\_\_\_

Signature

Date

Relationship to Patient (If other than patient): \_\_\_\_\_

Witness: \_\_\_\_\_

Printed Name- Patient or Representative

\_\_\_\_\_

Signature

Phone:

Fax:

Address