PATIENT PRIVACY & CONSENT

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 my treatment)

• Obtaining payment from third party payers (e.g. my insurance company);

• The day-to-day healthcare operations of your practice

I have also been 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 from time to time and that 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 health care operations, but that you are then bound to comply with this restriction.

I authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself:

_____   _____
Please print name   Relationship

_____   _____
Please print name   Relationship

May we leave messages on a home or cell phone voice mail about appointments/ treatment?   Yes   No

May we leave messages with or discuss your appointments/treatment with your spouse?   Yes   No   N/A

If you are over the age of 18, still living at home, may we discuss your appointments/ treatment with your parent(s) or guardian?   Yes   No N/A

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.

Print Patient Name: _____

Signature: _____Date: _____

Relationship to Patient: _____