Patient 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 (HlnA). I understand that by signing this consent form 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 (for example, the insurance company)

• The day to day healthcare operations of the practice.

I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices (on back of this form), which contains a more complete description of the uses and disclosures of my rights under HIPPA. I understand that the practice reserves the right to change the terms of this notice from time to time to obtain the most current copy of this notice.

I understand that I have the right to request restriction on how my protected health .information is used and disclosed to carry out treatment, payment, and healthcare operations, but that the practice is not required to agree to these requested restrictions. However, if the practice does agree, the practice is bound to comply with this restriction.

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

Signed this _____ day of _____ 20, _____

Print Patient Name _____

Relationship to Patient _____

Signature _____-_____