♦<u>Patient Consent Form</u>♦

I understand under the ***Health Insurance Portability & Accountability Act of 1996 (HIPAA)***, that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed and given the right to review the contents of your ***Notice of Privacy Practices***, which contains a more complete description of the uses and disclosures of my health information, prior to signing this consent. I understand that this organization has a right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at anytime to obtain a current copy of the ***Notice of Privacy Practices***.

I am aware that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. If the office does agree with my request, I am aware they are bound to abide by such restrictions. I also understand the office is not required to agree to my requested restrictions.

I understand that I may revoke this consent in writing at any time. Except to the extent that the office has taken action relying on this consent.

Patient Name:____

Signature:____

Relationship to Patient (if minor): ____

Date: ____