HIPAA Patient Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my 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 provides who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party players
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have been informed by you and your "Notice of Privacy Practices", containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such "Notice of Privacy Practices" prior to signing this consent. I understand that his organization has the right to change its "Notice of Privacy Practices" from time to time and that I may contact this organization at any time to obtain a current copy.

I understand that I may request in writing that you restrict my private information. Also that it is used or disclosed to carry our treatment, payment, or healthcare options. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time.

Patient name: _____

Signature: _____ Date: _____
(Parent/Guardian if under 18)