HIPAA consent Form

Sections A: Patient Giving Consent

Patient Name:

Address:

Telephone: Email:

Section B: To the patient---- Please read the following statement carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our notice of privacy practices before you decided whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of the other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our notice of privacy practices. If we change our privacy practices, we will issue a revised notice of privacy practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our notice of privacy practices, including any revisions of our notices, at any time by contacting the office.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received you revocation, and that we may decline to treat you or to continue treating you is you revoke this consent.

Section C: Signature

I,_____ have had full opportunity to read and consider the contents of this consent form and your notice of privacy practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date:_____

If this consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name:

Relations to Patient: