PRIVACY PRACTICES FORM (HIPAA)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The practice may condition receipt of treatment upon the execution of this Consent
- This document will be valid until the discharge of the patient.

DO WE HAVE YOUR PERMISSION TO:

- **Leave a message on your answering machine at home (including reminders for appointments)?** **Yes____No____**
- **Leave a message on your place of employment?** **Yes____No____**
- **Leave a message on your cellular phone?** **Yes____No____**
- **Discuss your medical condition with any other member of your household?** **Yes____No____**
  If yes, whom: _____
  Relationship: _____
  Please give any additional comments about the release of your medical condition(s) or appointments:
  _____
  _____

Patient's Name: _____

This Consent was signed by: _____ _____
Printed Name- Patient or Representative Signature

Relationship to Patient (if other than patient): _____ Date _____

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