

# **PATIENT CONSENT FORM (HIPAA)**

**Under Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have certain right to privacy, which are outlined in the HIPAA form provided. This information will be used to:**

- 1. Plan, conduct and direct your treatment and follow-up among multiple health care providers involved in your treatment.**
- 2. Obtain payment from third party payers.**
- 3. Conduct normal healthcare operations such as quality assessment and physician certification.**

**You have the right to review a NOTICE OF PRIVACY PRACTICES prior to signing this consent. This organization has the right to change its Notice of Privacy Practices from time to time and that you may contact this organization at anytime to obtain a copy of the Notice of Privacy Practices.**

**You may revoke this consent in writing at anytime.**

**Patient Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_