KENILWORTH
PRIMARY CARE
66 South 21st Street, Kenilworth, NJ 07033
Phone: (908) 276-9595 Fax: (908) 276-6807

HIPAA Consent Form

Please print & bring with you

I understand that I have some rights regarding my IIHI (Individually Identifiable Health Information), given to me by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). By signing this patient consent, I hereby authorize [*Please insert your company name here*] to use and disclose my health information for the following purposes:

- **Treatments:** Including other healthcare providers involved in my treatment.
- **Payments:** To obtain payments from any third party (including my insurer).
- **Healthcare operations:** Day-to-day healthcare operations at your clinic.

I have been given the right to inspect a copy of your Patient Privacy Policy, which details the use and disclosure of my health information and my rights regarding it. I understand that [*Please insert your company name here*] reserves the right to amend these polices from time to time and I can ask for a copy of the current policy statement anytime.

I also understand my rights to request restrictions on how you use and disclose my IIHI for various purposes, but you are not required to agree to my request. However, if you do agree, then you have to follow it.

I understand that I have the right to revoke this consent anytime, in writing. However, the use and disclosure of my IIHI that occurred prior to the date I revoke will not be affected.

Date: _____/_____/_____

Patient Name: ______ ____

Relationship to Patient: _____________ ____

Signature: ______________________________