HIPAA PATIENT CONSENT FORM

This consent form goes over the Health Insurance Portability & Accountability Act of 1996. HIPAA provides information about how we may use and disclose protected health information about you. This Notice contains a Patient's 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 be subject to change at any given point. If we change our Notice, you may obtain a revised copy by contacting our office, or going to our website, www.kidsandtummies.com.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, health care operations, and/or coordination of care.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, health care operations, and coordination of care. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures 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, health care operations, and/or coordination of care.
- The patient has the right to obtain and view the Notice of Privacy Practices containing a more complete description.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to look over and/or obtain a copy of their health care records with a signed release.
- The patient has the right to restrict the uses of their information.
- The patient may provide a written request to revoke this consent at any time during care.
- If the patient refuses to sign the consent form for purposes of treatment, payment, health care operations, and/or coordination of care, the Practice has the right to refuse care to the patient.

Patient Name _____ Date of Birth _____
(please print)

Patient/Guardian Signature_____ Today's Date_____

**** Parent or Guardian signature required for patients under the age of 18 years.****