



Notice of Privacy Practices Patient Consent Form and Authorization

Although we are a practice that does not participate in insurance, we will maintain your privacy of data to the highest standards.

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 care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made based upon your prior Consent.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice reserves the right to change the Notice of Privacy Practices.
- It is the duty of the practice to notify the patient of a breach to their health care information unless there is a low probability that the information has been compromised.
- 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 treatment upon the execution of this Consent.
- Individuals who may receive information regarding the contents of my patient record:

_____; _____
(FIRST) (MI) (LAST) (RELATION TO PATIENT)

_____; _____
(FIRST) (MI) (LAST) (RELATION TO PATIENT)

_____; _____
Print name - Patient or Guardian **Signature - Patient or Guardian**

Signature: _____

Relationship to Patient: _____ Date: _____