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PATIENT HIPAA CONSENT FORM

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.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare 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 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 healthcare 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 Policies.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

I authorize that your office may contact me in the following manner (check all that apply)

HOME TELEPHONE

- ☐ OK to leave message on machine with detailed message
- ☐ OK to leave message with call-back number only
- ☐ OK to leave message with family member (Who?_____)

WORK TELEPHONE

- ☐ OK to leave message on machine with detailed message
- ☐ OK to leave message with call-back number only
- ☐ OK to leave message with co-worker (Who?_____)

CELLULAR TELEPHONE

- ☐ OK to leave message on voicemail with detailed message
- ☐ OK to leave message with call-back number only

TREATMENT

- ☐ OK to disclosed information about treatment plan and options to (Who?_____)

_____/_____ _____

Signature of Patient or Guardian / Date of Birth **Date**

_____/_____ _____

Witness (Practice Representative) **Date**