**HIPAA COMPLIANCE PATIENT CONSENT FORM**

This Notice of Privacy Practices provides information about how we may use or disclose protected health information.

This notice contains a patients rights section describing your rights under the law. You asceretain that by your signature that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or health care operations. We are not required to agree with the restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1966) law allows for the use of the information for the treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

* Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
* The practice reserves the right to change the privacy policy as allowed by law.
* The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
* The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. \* The practice may condition receipt of treatment upon the execution of this consent.

May we phone,email,or send a text to you to confirm appointments? Yes\_\_\_\_ No\_\_\_

May we leave a message on your answering machine at home or your cell phone? Yes\_\_\_\_ No\_\_\_

May we discuss your medical condition with any other individual? Yes\_\_\_\_ No\_\_\_

If YES, please name:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent was signed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*We will accept written revocations of this authorization by Certified U.S. mail only. I fully understand and accept the terms of this authorization.

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Patient Signiture Date