HIPPA Compliance Patient Consent Form

Our Notice of Privacy practices provides information about how we may use or disclose protected health information.

The notice contains patient's rights section describing your rights under the law. You ascertain that by signature that you have reviewed our notice before signing thie consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare procedures. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allowes for the use of the information for treatment, payment, or healthcare procedures.

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 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 procedures.
- 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 disclosure will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we call or email you to confirm appointments? **Yes No**

May we leave a voice message to the provided phone number? **Yes No**

May we discuss your medical information with any member of your family? **Yes No**

If **YES**, please name the members allowed:

1. Name:_____ Relation to you: _____ Phone Number:_____

2. Name:_____ Relation to you: _____ Phone Number:_____

Patient Name(Print): _____
Last First

Parent/Guardian Name(Print): _____
Last First

Signature: _____ Date: _____