HIPAA Consent

I understand that as part of my healthcare, the practice originates and maintains paper and /or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means for communication among health professionals who contribute to my care, such as referrals
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

I have been provided with a "*Notice of Patient Privacy Practices"* that provides a more complete description of information uses and disclosures. I understand that I have the following and privileges:

- The right to review the "*Notice*' prior to acknowledging this consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, of healthcare operations.

Please Print

Restrictions

I request the following restrictions to the use or disclosure of my health information:

_____

_____

Please tell us with whom we may discuss your protected health information:
(Example: spouse (name), children (name(s)), other relatives (name(s), friends or caregivers (name(s))

_____

_____

Messages or Appointment Reminders

May we leave a message at your home using doctor's /practice name: ☐ Yes ☐ No

May we leave a message at your work using doctor's /practice name: ☐ Yes ☐ No

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law. I fully understand and ☐ accept ☐ decline the information of this consent.

Notice of Privacy Practices

I acknowledge that I have been provided with the Practices' Notice of Privacy Practices that provides a description of Protected Health Information use and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this statement. I understand that the Practice reserves the right to change its Notice of Privacy Practices that will be effective for health information the Practice already has about me, as well as any they receive in the future. The Practice3 will post a current copy of the Notice. I understand that I may obtain a copy of the current Notice in effect upon request. I have read all of the above and understand/agree to all the provisions therein regarding responsibility for payment, permission for treatment and Notice of Privacy Practices.

_____ _____

Patient/ Guardian Signature Date

_____

Printed Name of Person Signing Consent Form

If other than the patient (Patient Name)_____ is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations? ☐ Yes ☐ No