DATE: ____/____/____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the health insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent that I authorize you to disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and discloses of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out any treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree to them, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time period. However, any use or disclose that occurred prior to the date that I revoke this consent is not affected.

Patient Signature:_____Date:____/____/____

Patient Print:_____

Release of patient information to:_____Relationship:_____