HIPPA PATIENT CONSENT FORM

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

By signing this form, you consent to our use and disclosure of protected healthcare information. 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, you understand that:

□Protected health information may be disclosed or used for treatment, payment, or healthcare operations, including email and text updates about office events and promotions.

□The Practice reserves the right to change the privacy policy as allowed by law.

□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 execution of this consent.

May we discuss your medical condition with members of your family? □ YES □ NO

If yes, please name the family members allowed:

Name: _____ Relation: _____ Date of Birth: _____

Name: _____ Relation: _____ Date of Birth: _____

Name: _____ Relation: _____ Date of Birth: _____

Name: _____ Relation: _____ Date of Birth: _____

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

PRINT YOUR NAME _____

SIGNATURE _____ DATE _____

□ ARE YOU THE PATIENT

□ ARE YOU THE GUARDIAN/REPRESENTATIVE