HIPAA PATIENT CONSENT FORM

One Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review on Notice before signing this Consent. The term of our Notice may change. If you change our Notice, you may obtain a revised copy by contacting our office, or going to our Website.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

* Protected health information may be disclosed or used for treatment, payment, or health care operations.
* The Practice Has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
* The Practice reserves the right to change the Notice of Privacy Polices.
* The Patient has the right to restrict the uses of their information.
* The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
* The Patient may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day services payment in full for any services will be required.

This HIPAA Consent was signed by_____ _____

Signature of patient or guardian Printed name of same

Relationship to the patient (if other than patient) _____ _____

Please print Today's date

Signature of practice representative: _____