PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

You have informed me of your *Notice of Privacy Practices* containing a more complete description of the users. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at the time, except to the extent that you have taken action relying on this consent.

Patient Name: ____

Signature: ____

Relationship to Patient: ____

Date: ____/____/______

AUTHORIZATION TO RELEASE INFORMATION TO:

1)____

2)____