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PATIENT CONSENT FORM

I understand that the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain 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 payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practice* containing a more complete description of the uses and disclosure of the uses and disclosure of my health information. I have been given the right to review such *Notice of Privacy Practice* prior to signing this consent. I understand that this organization have 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 healthcare operations. I also understand you are not required to agree to my requested instructions, but if you do agree then you are bound to abide by such restrictions.

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

First Name ______________________

Middle Name / MI ______________________

Last Name ______________________

Signature

Relationship to Patient: ______________________

Date ______________________