PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights regarding my protected health information. I understand that this is 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 or your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 it 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 this 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 not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

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

I also authorize this practice to disclose my medical information

On my answering machine/voicemail	Yes____	No____
To my spouse	Yes____	No____
To my adult children	Yes____	No____
To the following additional family and or friend(s) Name:_____		

_____ _____

Signature of Patient Date

Please use the following signature lines if the patient is a minor or otherwise incapacitated (physically or mentally).

_____ _____ _____

Signature of: Patent/Guardian/Personal Representative | Description of authority | Date