HIPPA

PATIENT CONSENT FORM

There is a copy of the complete policy available in the waiting room or by asking the office manager to supply a copy.

I (Patient name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ /\_\_\_\_\_

grant permission for the following person(s) to obtain information regarding my medical care and speak with the provider and/or staff regarding my care.

Name: Relationship:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The patient understands that:

Protected health information may be disclosed or used for treatment, payment or health care operation. This practice has a notice of privacy practices and the patient has the opportunity to review this notice. This practice reserves the right to change the notice of privacy practices. Patient has the right to restrict the uses of the information, but the practice does not have to agree to those restrictions. The patient may revoke this consent in writing at any time and all future disclosures will then cease. The practice may condition receipt of treatment upon the execution of this consent.

Patient or responsible party signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_\_