Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out :

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
Obtaining payment from third party payers (e.g. my insurance company)
The day-to-day healthcare operations of your practice.

I have also been informed and given the right to review and secure a copy of Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you may reserve the right to change the terms of this notice from time to time and I may contact you at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at this time. However, any use or disclosure that occurred prior to that date I revoke this consent is not affected.

Signed this_____ day of_____, 2_____.
Printed Patient Name_____
Relationship to Patient _____
Signature _____

Response Date: _____