HIPAA CONSENT

I give the practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practices/clinic's NOTICE of PRIVACY PRACTICES (see office for more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my request restriction, they must follow the restriction(s).

I also understand that I may revoke the consent at the any time, by making request in writing, except for information already used or disclosed.

By the way of my signature, I provide this practice/clinic with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment, and health care operations as described in the Privacy Notice

_____ _____

Signature (patient, parent or legal guardian) Date

If signed by a patient representative, state relationship to patient_____