Patient Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA); I have certain rights 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 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 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.

(Please Print)

Patient Name:

Signature:

Relationship to Patient:

Date:

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