PATIENT PRIVACY 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 (HIPPAA). 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.
- Obtaining payment from third party payers (IE: my insurance).
- The day-to-day operations of your practice.

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

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations but you are not required to agree to these restrictions.

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

I give my consent to send a recall postcard. I give my consent to leave a pre-medicate reminder and/or confirmation message on my answering machine. I agree to have insurance payment checks sent directly to my provider.

Signed this _____day of _____,20_____.

Print Patient Name:_____.

Relationship to Patient:_____.

Signature: _____.