HIPAA 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 (HIPAA). 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 health care 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 HIPAA. 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 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.

PRINT PATIENT NAME: ____

RELATIONSHIP TO PATIENT: ____

SIGNATURE: ____

DATE: ____

( ) You may discuss my medical/dental information or billing questions with the following person(s):

___

( ) Please do not discuss my medical/dental information with the following person(s):

___

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