HIPAA LAW – RIGHT TO PRIVACY – CONSENT

I give this practice my consent to disclose my protected health information, in order to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews.

I may review this office's "Notice of Privacy Practices", for a more complete description of the uses and disclaimers, before signing this consent.

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

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

Signature of patient over 18 years of age:

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(print & sign name) (date)

OR:Signature of patient representative and relationship to patient (If patient is under age 18 or cannot sign due to limitations).

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(print & sign name & relationship to patient)

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Other then yourself, who is authorized to discuss your health information?_____