Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under 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 healthcare operations of your practice to include but not limited to:
  - Phone messages left on answering machines or voicemails with date and time of scheduled appointments- even without the outgoing voice mail message identifying by name the recipient of the message.
  - Communications to other healthcare providers or me, as the patient, to include but not limited to appointment or treatment information, by phone, mail, open postcards, e-mail, or other electronic devices.

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 recent copy of this notice.

I understand that I have to right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However if you do agree, you are then bound to comply with this restriction.

I give consent for messages regarding my medical, financial, or appointment information to be left with: (please initial by each you consent to receive messages)

___parent ___grandparent
___children ___other(s): ______________________________
___spouse ___other(s): ______________________________
___ anyone who answers home or cell number

I give consent for messages regarding my medical, financial, or appointment information to be left on my: (please initial by all that apply)

___Home phone ___Cell phone ___Work phone
___Other: ____________________

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.

Signed this ____day of____________, 20___.

Print Patient name: ____________________ Relationship to patient: ________________

Signature:____________________________

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