MOTHERHOOD TO MENOPAUSE
MIDWIFERY CARE

HIPAA PRIVACY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand 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 (i.e., my insurance company)
- The day-to-day healthcare 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 I have the right to request restrictions on how my protected health information is used and disclose to carry out treatment, payment, and health care operations, but that you are not required to agree, you are then bound to comply with this restriction.

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 revoked this content is not affected.

CLIENT'S PRINTED NAME_____**DOB**_____

CLIENT'S SIGNATURE_____**DATE SIGNED**_____