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 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 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 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 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 also acknowledge that I have received a copy of this practice’s Notice of Privacy Practices for Protected Health Information. I have been given the opportunity to ask any questions I may have regarding this Notice.

**I wish to be contacted in the following manner (*check all that apply*):**

Home Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Written Communication \_\_\_\_\_\_

Okay to leave message with detailed information Okay to mail to my home address

Leave message with call-back number only Okay to mail to my work/office address

Okay to fax to number indicated

I allow you to give my clinical information to or answer questions from (*check all that apply*):

 Spouse \_\_\_\_\_\_ Parent \_\_\_\_\_\_ Child \_\_\_\_\_\_

 Other (specify) \_\_\_\_\_\_ None \_\_\_\_\_\_

I have read and understand all of my privacy rights.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_