## HIPPA Patient Consent Form

I, ____________________________, consent to the use or disclosure of my protected health information by **Incredible Family Health & Wellness** for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of **Incredible Family Health & Wellness**. I understand that diagnosis or treatment of me by **Incredible Family Health & Wellness** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction on how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Incredible Family Health & Wellness** is not required to agree to the restrictions that I may request. If **Incredible Family Health & Wellness** agrees to the restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Incredible Family Health & Wellness** has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a medical insurance provider, or my employer. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Incredible Family Health & Wellness** “Notice of Privacy Practices” prior to signing this document. The **Incredible Family Health & Wellness** has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of the healthcare operation of **Incredible Family Health & Wellness**. The Notice of Privacy Practices is provided at **Incredible Family Health & Wellness**. This Notice of Privacy Practices also describes my right and **Incredible Family Health & Wellness** duties with respect to my protected health information.

**Incredible Family Health & Wellness** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT AND UNDERSTAND IT. DO NOT SIGN THIS FORM IF YOU HAVE TAKEN ANY MEDICATIONS, WHICH MAY IMPAIR YOUR MENTAL ABILITIES.

Print Name________________________________________ Date__________________

Patient Signature__________________________________________

Witness__________________________________________________