Beachside Neurology
HIPAA Privacy Acknowledgment & Patient Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) requires healthcare providers to protect the privacy of patients' medical information. This form explains how [Practice Name] may use and disclose your Protected Health Information (PHI) and outlines your rights regarding your medical records.

By signing this form, you acknowledge that you have been informed of your privacy rights and consent to the use of your PHI for treatment, payment, and healthcare operations.

I acknowledge that:

1. I have received and reviewed the Notice of Privacy Practices for Beachside Neurology, which explains how my PHI may be used and disclosed.
2. I understand that PHI may be used for:

● Treatment (sharing with other healthcare providers for coordinated care). ● Payment (billing insurance providers, verifying coverage, and processing claims).
● Healthcare operations (quality assessments, staff training, legal compliance).

3. I understand that I have the right to:

● Request restrictions on certain uses and disclosures of my PHI. ● Obtain a copy of my medical records.
● Request corrections to my medical information.
● File a complaint if I believe my privacy rights have been violated.

By signing below, I authorize Beachside Neurology to:

1. Share my medical information with the following individuals (optional):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Communicate with me via:

● ☐ Phone (☐ Voicemail OK)
● ☐ Email
● ☐ Text Message

I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken.

Patient Signature: _____ Date: _____