aps | Advanced Professional Services

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our Notice of Privacy Practices before signing this consent.

The terms of the Notice of Privacy Practices may change. If this happens, you will be notified and asked at your next visit to review the changes and complete an updated HIPAA Compliance Consent Form.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or health care operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA(Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or health care operations.

By signing this form, you consent to our use and disclosure of your protected health care information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosure will cease upon receipt of the revocation.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send you a text to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your voicemail? YES NO

May we discuss your medical condition(s) with a family member or authorized person? YES NO

● If YES, please list below the name(s) and relationship(s) of any persons that we may discuss your medical condition(s) with:

_____

Patient's Name: _____ Date of Birth:_____

Signature: _____Date: _____

Relationship to patient (if not self): _____