**HIPPA Compliance Patient Consent Form**

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

By signing this form, you consent to our use and disclosure of your protected healthcare information for your treatment. You have the right to revoke this consent in writing, signed by you.

You are consenting to our contacting your physician about our recommendations for your healthcare.

By signing this form, I understand that:

* Protected health information may be disclosed or used for treatment.
* You have 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 disclosures will then cease.
* The practice may condition receipt of treatment upon execution of this consent.

May we discuss your medical condition with any member of your family? Yes No

If yes, Please give name of members allowed:

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This consent was signed by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (PRINT NAME PLEASE)

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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