HIPPA Consent

Name:_____ **Date of birth:**_____ **Date completed:**_____

I authorize my provider and office staff at AVP Primary Care, PLLC to discuss my private healthcare information with the following people:

Name	Relationship	Phone number	Address

I understand that as part of my healthcare, AVP Primary Care, PLLC will need to contact me from time to time regarding my private healthcare information. I understand that my provider and office staff will use the minimum information necessary when they communicate with me indirectly. I hereby authorize AVP Primary Care, PLLC, to contact me in the follow ways:

Home phone number	Cell phone number	Work phone number	Fax

Email: _____

I understand that I have the right to revoke or amend this agreement at any time, in writing, with the provider or staff of AVP Primary Care, PLLC. Any revocation or change will not apply to communications already completed.

I understand that as part of my health care, AVP Primary Care, PLLC, originates and maintains paper and electronic records describing my health history. I understand that this information serves as: (i) basis of planning my care and treatment; (ii) means of communication among the healthcare professionals who contribute to my care; (iii) source of information for applying my diagnosis to my bill; (iv) means by which a third-party payer can verify that services billed were actually provided; (v) tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected healthcare information to another entity, as specified above. I fully understand and accept the terms of the consent.

Please sign and date below:

_____ _____

Signature of Patient / Legal Guardian Date