



HIPAA Patient Consent Form

This practice is committed to maintaining the privacy of your protected health information (PHI) which includes information about your health condition and the care and treatment you receive from the practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality care. This Notice details how your PHI may be used and disclosed to third parties. This Notice also details your rights regarding your PHI. You have the right to review our Notice before signing this Consent and you are advised to do so. The privacy of PHI in patient files will be protected when the files are taken to and from the practice by placing the files in a box or brief case and kept within the custody of a doctor or employee of the practice authorized to remove the files from the practice's office.

The patient understands that the practice:

Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.

Is required to abide by the terms of this Privacy Notice.

Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

Will make any revised Privacy Notice available to you per your request.

Will not retaliate against you for filing a complaint.

May disclose your PHI for treatment, payment, emergency situations and/or health care operations.

Gives the patient the right to revoke this Consent in writing at any time and all future disclosures that require the patient's prior written consent will then cease.

Printed Name of Patient

Date

Signature

Date

Witness

Date

Patient Refused to Sign

Patient unable to sign