HIPAA Compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information. You may review our Privacy Practices at any time. By signing this form, you consent to our use and disclosure of your restricted health information in order to bill your insurance and communicate with other physicians involved in your care. You have the right to revoke this consent at any time, as long as it is provided in writing. This revocation will not be retroactive.

By signing this form, I understand that:

- Protected information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosure will cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? Yes No

May we leave a message on your answering machine or cell phone? Yes No

May we discuss your medical conditions with anyone in your family? Yes No

If yes, please name the family members allowed:_____

This consent was signed by:_____
Print Name

Signature:_____ Date:_____