HIPAA Consent

I give this practice my consent to use or disclose my protected health information to carry out my treatment, and to obtain payment from insurance companies.

I have been informed that I may review the practice Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing the consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____ Date: _____

Patient, parent, or legal guardian

If signed by patient representative, state relationship to patient: _____