



Health Insurance Portability and Accountability Act (HIPAA)

Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that: Protected health information may be disclosed or used for treatment, payment, or health care operations. We otherwise do not disclose any of your health care information to private parties, third party vendors, lawyers or friends and family unless you previously permitted this in writing. The patient has the right to restrict the uses of their information but V5 does not have to agree to those restrictions. V5 may condition receipt of treatment/services upon the execution of this Consent.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

This consent was signed by:

Printed Name-Patient or Responsible Party

Patient Signature or Responsible Party Date

Relationship to patient (if other than patient)

Witness:

Printed Name-Practice Representative

Signature

Date