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HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this provider has the right to change its Notice of Privacy Practices from time to time, and that I may contact this provider at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that this provider restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand the provider is not required to agree to my requested restrictions, but if the provider does agree, then they are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Name

DOB (mm/dd/yyyy)

Signed (Patient or Legal Representative for Patient)

Today's Date

Legal Representative's Relationship to Patient