Patient Consent

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

1. Conduct, plan and direct my treatment an follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments 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. I have been given the right to review such **Notice Of Privacy Practices** prior to signing this consent. I understand that this organization has the right to change its **Notice Of Privacy Practices** from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the **Notice Of Privacy Practices.**

I understand that I may request in writing that you restrict how my practice information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do not agree then you 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 you have taken action relying on this consent.

PATIENT NAME:_____

SIGNATURE:_____

RELATIONSHIP TO PATIENT:_____

DATE:_____