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Patient Consent Form

This form is to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Signing this form allows us to disclose protected health information about you for treatment, payment and health care operations. Signing this form constitutes consent to use or disclose protected health information.

The patient understands and agrees that:

This office has a Notice of Privacy Practices. You have had an opportunity to review this notice and have received a copy.

We reserve the right to change the Notice. If we change the notice you may obtain a revised copy contacting our office in writing.

The patient has the right to restrict the uses of their information but we are not obligated to agree to those restrictions.

This consent can be revoked at any time in writing and all future disclosures will stop.

Treatment may be conditioned upon execution of this consent.

Signature:_____

Relationship to Patient (if other than patient):_____

Date:_____

Witness:_____ **(Practice Representative)**