PATIENT CONSENT FORM

The Health Insurance Portability and Accountability Act of 1995 (HIPAA), requires medical practices to establish policies to protect the privacy of patient health information and inform how their information will be used or disclosed. The patient or the parent has the right to review our complete Notice of Privacy Practices at any time.
By signing this form, I understand the following:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The parent or patient may request restriction of use of disclosure of protected health information for treatment, payment or health care operations. However, the practice has the right to deny this request.
- Other uses or disclosure of protected health information will require a separate authorization signed by the patient or parent.
- The patient or parent may revoke this consent at any time; however treatment may be conditional upon execution of this consent.

Patient's full name:_____

Signature: _____ Date: _____

Relationship to patient (if signed by parent or guardian): _____

FOR OFFICE USE ONLY

This acknowledgement could not be obtained because:

Individual refused to sign it.
Communication barriers prohibited obtaining it.

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