PATIENT CONSENT FORM

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTION HEALTH INFORMATION. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED, BUT IS NOT MANDATORY FOR ME TO SIGN IN ORDER TO:

1. CONDUCT PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMOUNG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY & INDERECTLY

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 COMPLETED DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I HAVE BEEN GIVEN A COPY OF YOUR NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT. I UNDERSTAND THAT THIS ORGANIZATION HAS A RIGHT TO CHANGE IT'S NOTICE OF PRIVACY PRACTIES FROM TIME TO TIME YOU MAY CONTACT THIS ORGANIZATION AT ANY TIME TO OBTAIN A CURRENT COPY OF THE PRIVACY ACT.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. I UNDERSTAND THAT YOU CAN DECLINE BUT IF YOU AGREE THAT YOU ARE BOUND TO ABIDE BY SUCH RESTRICTION.

PATIENT NAME:_____

SIGNATURE:_____

RELATIONSHIP TO PATIENT:_____

TODAY'S DATE:_____