



HIPAA

Acknowledgement of Receipt of Privacy Practices and Consent for Use and Disclosure of Health Information

The Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how a patient may access his or her information. Patients have the right to read our Notice of Privacy Practices before deciding whether to sign this consent. A copy of the Notice is available upon request. The Notice provides a description of the uses and disclosures of a patient's protected health information for treatment, payment activities and healthcare operations.

Purpose of Consent: By signing this form, patients consent to the use and disclosure of his or her protected health information to carry out treatment, payment activities and healthcare operations.

Agreement: I have had the opportunity to request a copy of the Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

By my signature below I acknowledge receipt of the Patient Notice of Privacy Practices and Patient Rights & Responsibilities.

Patient Name (Print) _____

Date of Birth _____

Signature _____

Date Signed _____