



HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and 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: Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly. Obtain payment from designated third-party payers. Conduct normal health care operations such as quality assessments or evaluations 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 (available in the office in print form).

I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. 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 above to obtain a current copy of the Notices of Privacy Practices. I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Name _____ DOB: (mm/dd/yy) _____

Signed (Patient or Legal Representative for Patient) _____ Date: _____

Legal Representative's Relationship to Patient _____