Privacy Practice Notice (HIPPA)

* Required

1. **NAME** *

2. **Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law for protection of your health information. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice or if you would like further information about our privacy policies, you may obtain this information by contacting our office.You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).** *

   Mark only one oval.

   - Yes
   - No

3. **The patient understands that: Protected health information may be disclosed or used for treatment, payment or health care operations** *

   Mark only one oval.

   - Yes

4. **You understand that the Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice** *

   Mark only one oval.

   - Yes

5. **You understand The Practice reserves the right to change the Notice of Privacy Practices** *

   Mark only one oval.

   - Yes

6. **You understand the patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions** *

   Mark only one oval.

   - Yes

7. **You understand that you may revoke this Consent in writing at any time and all future disclosures will then cease** *

Mark only one oval.

( ) Yes

8. **You understand that the Practice may condition receipt of treatment upon the execution of this Consent**

Mark only one oval.

( ) Yes

9. **Patient/Legal Guardian Electronic Signature** *

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10. **Date** *

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Example: December 15, 2012

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