HIPAA Compliance Patient Consent Form

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Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.
The notice contains a patient's rights section describing your rights under the law. You represent by your signature that you have reviewed our notice before signing this consent.
The terms of the notice may change, and if so, you will be notified at your next visit to update your signature/date.
You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations.
We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.
By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you for the purposes described above?

○ YES ○ NO

May we phone, email, or send a text through computer or dialing equipment with an artificial or prerecorded voice or a computergenerated text message to inform you of promotional services offered by us or our affiliated entities? This consent is not required for treatment and may be revoked at any time. Messaging and data rates may apply.

○ YES ○ NO

May we leave a message on your answering machine at home or on your cell phone?

○ YES ○ NO

May we discuss your medical condition with any member of your family?

○ YES ○ NO

My cell phone number is

(___) ___-____

My landline is

(___) ___-____

My email address is

This consent was signed by

NAME PLEASE

Signature *

Date

10/16/2024

Witness

Date

10/16/2024

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

For office use only:

Patient refused to sign. The following circumstances prohibited the patient from signing the acknowledgment

Office Personnel Name

Date

10/16/2024

Office Personnel (signature)