



## PATIENT ACKNOWLEDGEMENT AND CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I consent to this formation being used to:

- **Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved directly or indirectly in that treatment.**
- **Obtain payment from third-party payers, which can include electronic filing of insurance.**
- **Conduct normal healthcare operations such as quality assessments and professional certifications.**

I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosure of my health information. I understand that you have the right to change the *Notice of Privacy Practices* from time to time and that I may contact this office at any time to obtain a copy of the current *Notice of Privacy Practices*.

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 also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_