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PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have the certain right 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 among the multiple healthcare providers who may be involved in that treatment directly and in indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians certification

(A COPY OF THE PRIVACY NOTICE IS POSTED IN THE FRONT OFFICE)

I have received, read and understand your NOTICE OF PRIVACY PRACTICE containing more complete description of the uses and disclosures of my health information. I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing this consent. 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 about to obtain a current copy of the NOTICE OF PRIVACY PRACTICE.

I understand that I may request in writing that you restrict how my private information is used for disclosed to carry out treatment, payment or healthcare 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:__________________________