Patient Consent Form

972.608.4746
972.608.4749 fax

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this form can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare provides who may be involved in that treatment directly and indirectly
- Obtain payment from third- party payers
- Conduct normal healthcare operations such as quality assessments and physician certification

I have been informed by the organization of their *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information have informed me. 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 below to obtain a current copy of the *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 anytime, except to the extent that you have taken relying on this consent.

Patient(s) Name(s): _____

Legal Guardian Signature: _____

Relationship to Patient(s): _____

Date: _____