Consent and Notice of Privacy Practices

I understand the Health Insurance Portability and Accountability Act of 1996 (HIPPA) provides me certain rights to privacy regarding my protected health information.
I understand 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 indirectly. The information may also be used to conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by this organization of the Notice of Privacy Practices containing a 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 from time to time and contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand I may request in writing a restriction of how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the facility is not required to agree to my requested restrictions, but if the facility does agree then they are bound to abide by such restrictions.

I understand I may revoke this consent, in writing at any time, except to the extent that the facility has taken action relying on my signed consent.

Patient Signature_____ Date _____

Witness Signature_____ Date _____

Copy to patient, Copy to patient file.