PATIENT CONSENT FORM

I understand that under **the Health Insurance Portability & Accountability act of 2010 (HIPPA),** I have certain rights to pri regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up amo multiple healthcare providers who may be involved in that directly and indirectly.
2. Obtain payment form third party payers.
3. Conduct normal health care operations such as quality ass and physician certifications.

I have been informed by you of your **Notice of Privacy Practices** c more complete description of the uses and disclosures of my health i have been given the right to review such Notice of Privacy Practices time and that I may contact this organization at any time at the addre obtain current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my pr information is used or disclosed to carry out treatment, payment or h operations. I also understand you are not required to agree to my rec restrictions, but if you do agree then you are bound to abide by such

I understand that I may revoke this consent in writing at anytime, exc extent that you have take action relying on this consent.

Patient Name: ______________________________

Signature: ______________________________

Relationship to Patient: ______________________________

Date: ______________________________