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HIPAA – Consent Form for Patients

Acknowledgement of Receipt of Notice of Privacy Policies and Consent for Disclosure for Treatment, Payment and Operations

ACKNOWLEDGEMENT AND CONSENT

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office including the mailing of appointment cards reminding me of my next appointment date and time, as described in the Notice.

Signature of the Patient of Personal Representative

Print Name of Patient or Personal Representative (including description of legal authority)

Date