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## HIPAA ACKNOWLEDGEMENT & CONSENT FORM

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's Notice of Privacy Practice by initialing here \_\_\_\_\_.

Our Notice of Privacy Practice states that we reserve the right to change the terms described. Should this happen, we will issue a revised Notice of Privacy Practice containing the changes.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, and health care operations. We are not required to agree to your restrictions. If we do, we are bound by our agreement with you.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent in writing, except where we have already made disclosures in trust on your prior consent.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Patient (please print): \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_

Phone Number: (     ) \_\_\_\_\_

If this Consent is being signed by a personal representative of the patient(s), provide the following information (please print):

Personal Representative's Name: \_\_\_\_\_

Relationship to and Name of Patient: \_\_\_\_\_

You are entitled to a copy of this Acknowledgement and Consent after you sign it.