HIPPA Privacy Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operation of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of my rights under HIPPA. I understand that the terms of this notice may change and that I may contact you to obtain the most current copy of this notice.
I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke is not affected.

Acknowledgement of Receipt

I have received a copy of the Notice of Privacy Practices

_____ Date_____

Patient or Guardian Signature

OFFICE USE ONLY

Our office made a good faith effort to obtain an Acknowledgement of Receipt of our Notice of Privacy Practices. Signature could not be obtained for the following reason.

o Patient refused to sign
o Emergency kept us from obtaining patient's signature
o Language barriers kept us from obtaining patients signature
o Other:_____