PATIENT HIPPA CONSENT FORM

Our practice has a program of Health Information Privacy Policies and Procedures to protect the interest of you, our valued clients. These are based on requirements of the Health Insurance Portability and Accountability Act (HIPPA) under the Department of Health and Human Services.

As of April 14, 2003 all healthcare providers are required to post this notice and to make a good faith effort to obtain signed consent from their patients. This consent form is legally necessary for us to assist you with tasks such as insurance pre-approval and filing, medical consultations if necessary, laboratory coordination and even appointment reminders.

I have read, reviewed and considered the contents of this consent form. I understand that by signing this consent form, I am giving my consent to your disclosure and use of mine or my dependents protected health information in any form deemed necessary in conjunction with common practices and professional judgment.

Patient Name: _____ Date of Birth: _____

Patient/Guardian Signature: _____

Your right to revoke consent:

You have the right to revoke consent by giving us written notice of your revocation. We retain the right to decline to treat you or continue treatment should you choose not to sign this consent or choose to revoke it at a later time.

You are entitled to a copy of this consent after it is signed. We support your right to the privacy of your health information. If you have any further questions about our Health Information Privacy Policies and Procedures, please inquire at the reception desk.