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HIPAA Compliance Patient Consent

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosure will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone to you to confirm appointments? YES NO

May we text to you to confirm appointments? YES NO

May we email to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on you cell phone? YES NO

May we discuss your medical condition with any member of you family? YES NO
If yes, please name the members allowed:

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May we discuss your medical condition with your physician(s)? YES NO
If yes, please name each physician allowed:

____

____

This Consent was signed by: ____________________________________
PRINT

Signature: ____________________________________

Date: ____________________________________