Patient name:__________________________

Chart #:________________

Place Stamp →

Phone:_____________ Fax:_______________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

SECTION A: PATIENT INFORMATION

____
Patient Name

____
Street Address

____
Social Security Number

____
City, State, Zip Code

____
Telephone

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about our protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy policies as described in our Notice of Privacy Practices. Such changes may apply to any of your protected health information that we maintain. If we change our privacy practices, we will revise the Notice of Privacy Practices and make the new Notice available up request.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer listed at the end of the Notice of Privacy Practices. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SECTION C: PATIENT OR REPRESENTATIVE SIGNATURE

I, ____, have received a copy of this office's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information, or the protected health information of the patient I am representing**, to carry out treatment, payment activities, and health care operations.

____
Signature

____
Date

**If this Consent is signed by a representative on behalf of the patient, complete the following:

____
Patient's Name

____
Relationship to the Patient

SECTION D: REVOCATION OF CONSENT

******ONLY SIGN THIS SECTION IF YOU WISH TO REVOKE YOUR CONSENT******

I revoke my Consent for your use and disclosure of my protected health information, or that of the patient I am representing, for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me, or the patient I am representing, after I have revoked my consent.

____
Signature

____
Date