Patient HIPAA Compliance Form

Our Notice of Privacy Practice provides information about how we use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

May we phone, email, or send a text to you to confirm appointments? YES____ NO _____

May we leave a message on your answering machine/voicemail

at home or on your cell phone? YES ____ NO _____

May we discuss your medical condition with anyone other than you? YES____ NO _____

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____