HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my Protected Health Information (PHI) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent form I authorize you to discuss and disclose my protected health information with the named person to carry out the processing of my appointments and necessary treatment.

I understand that I may revoke this consent, in writing, at any time; however, any use of disclosure that occurred prior to the date I revoked this consent is not affected.

Patient Name: ____

Name of Person Being Given Consent: ____

Relationship: ____

Date of Birth: ____________________