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HIPPA Acknowledgement and Consent Form

I understand that under the Health Portability and Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

Obtain payment from designated third-party payers.

Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent and acknowledge that I have studied the Privacy Practices. I understand that this organization at any time at the address above to obtain a copy of the Notices of Privacy Practices.

Patient's Name (printed)

DOB: (mm/dd/yy)

Signed (Patient or Legal Representative for Patient)

Date :
