

Patient Consent Form

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. We would like to inform you that some of the treatment may be performed in an open-air environment and if you prefer a more private setting please inform us and we will do everything to accommodate your wishes.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. In addition, we'd like you to know, we do not release or sell information to telemarketers, mailing houses or e-commerce Internet marketers.

You may refuse to consent the use of disclosure of your personal health information, but this must be in writing. Under this law we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI).

If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our Health Insurance Portability and Accountability Act (HIPAA) Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. By your signature below you acknowledge receipt in the form of a copy of the Compliance Assurance Notification and acceptance of this privacy policy.

Print Name: _____

Signature: _____ Date: _____