



HIPAA CONSENT FORM

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZED AND RELEASE FORM

You may refuse to sign this acknowledgement and authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledge receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this document shall be as effective as the original.

MY SIGNATATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER DOCTOR/FACILITIES IN THE FUTURE.

Please **PRINT** name of Patient

Please **SIGN** for Patient/Legal Guardian

Representative/Guardian

Relationship to Patient

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT, HEALTH, AND/OR BILLING INFORMATION VIA:

Home Phone _____

Text Message _____

Work Phone _____

Email _____

Cell Phone _____

Any of the Above _____

Signature: _____

Date: _____