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PATIENT PRIVACY POLICY
CONSENT & ACKNOWLEDGEMENT FORM

This consent will apply to all healthcare providers employed by and acting for the benefit of this office who conduct, plan and direct treatment and follow-up and may be involved in treatment, directly or indirectly.

In the course of providing services to you, this office will create, receive and store heath information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services and to conduct day to day health care operations.

The Notice of Privacy Practices describes the uses and disclosures in detail. The use and disclosures of your health information may include care and services, follow-up care from another health professional, disclosures of your information for billing purposes of processing claims for obtaining payment, or submission of claims to a third-party payer or insurer.

You have the right to restrict the use or disclosure made for purposes of treatment or healthcare operations, but this office is not obligated to agree to these restrictions. If this office does agree, however, the restrictions are binding. You may revoke this consent in writing at any time, except to the extent that this office has taken action relying on this consent.

I have read this document and understand it. I consent to the use and disclosure of my personal health information for purposes of treatment, payment and healthcare operations. I have received a copy of the Notice of privacy Practices from this office.

Date: _____ Signature: _____

Patient Name: _____

Relationship to Patient: _____