Consent to Treatment and Acknowledgement

(This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully)

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its notice of privacy practices from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing, except to the extent that the action has already been taken in reliance thereon.

I agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

I, ____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM. I understand that this consent shall remain in force from this time forward.

Patient Name: ____

Relationship to Patient: ____

Signature: ____

Date: ____