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## **PATIENT CONSENT FORM**

I understand that under the Health Insurance 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 among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- ❖ Obtain payment from third-party payers.
- ❖ Conduct normal healthcare operations such as quality assessment and physician certificate stations

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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 address above to obtain a current copy of the notice of privacy practices. This information is also posted on my webpage for immediate review at [Michellevanduinenaapr.com](http://Michellevanduinenaapr.com).

I understand that my 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 that you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, ask except to the extent that you have taken action relying on this consent

**Printed Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_