Acknowledgement of Receipt of Notice of Privacy Practices Consent for Use and Disclosure of Health Information and Release Form

Health Insurance Portability and Accountability Act

H I P P A Certified

Patient/Guardian Giving Consent:

Name _____

Address _____

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____

Our practice has implemented a program of Health Information Privacy Policies and Procedures to protect the interest of you, our valued patients. These are based on the requirements of the Health Insurance Portability and Accountability Act, H.I.P.P.A., under the Department of Health and Human Services.

As of April 14, 2003 all Healthcare Providers are required to post this notice and to make a good faith effort to obtain signed Consent from their patients. The Consent form is legally necessary for us to assist you with, but not limited to tasks such as Insurance pre-approval and filing, medical consultations if necessary, laboratory coordination and even appointment reminders.

I, _____, have read, reviewed and considered the contents of this Consent form and was given a copy of and have read your Notice of Privacy Practices. I understand, that by signing this Consent form, I am giving my consent to your disclosure and use of mine or my dependants (Minor Child, Foster Child or other person whom I am legal guardian of) protected health information in any form deemed necessary in conjunction with common practices and professional judgment.

_____ _____

Signature Date

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

_____ _____

Signature of Personal Representative Date

_____

Please Print Name of Personal Representative

Your Right to Revoke Consent

You have the right to revoke this Consent by giving us written notice of your revocation. We retain the right to decline to treat you or to continue treatment should you choose not to sign this Consent or choose to revoke it at a later time.

You are entitled to a copy of this Consent after it is signed. We support your right to the privacy of your health information. If you have any further questions about our Health Information Privacy Policies and Procedures, please inquire at the reception desk.

_____ Request **of exemption -** Please write your exemption request on back of this form.

Drs Hicks and Staff