HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting the office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if do, we shall honor agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

1. Protected health operations may be disclosed or used for treatment, payment or health care operation.
2. The patient may forbid disclosure of information about a test or treatment for which the patient has paid out-of-pocket.
3. The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
4. The Practice reserves the right to change the Notice of Privacy Practices.
5. The patient has the right to restrict uses of their information but the practice does not have to agree to these restrictions.
6. The patient may revoke the Consent in writing at any time and all future disclosures will then cease.
7. The Practice may condition receipt of treatment upon execution of this consent.

This consent was signed by _____

Printed name-patient or representative

_____

Signature Date

Relationship to patient _____

Witness _____

Printed name-practice representative

_____

Signature Date

Dr Modly has my permission to leave messages via phone for appointment confirmations
(please circle) YES NO