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PATIENT CONSENT FORM

In response to the misuse of Personal Health Information (PHI), the Department of Health and Human Services has established a "PRIVACY RULE" to help insure that PHI is kept private. This rule was also established in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient in order to carry out treatment, payment, or other health care operations.

We want you to know that we respect the privacy of your personal medical records and will take all reasonable measures to secure and protect your privacy. When necessary, we will provide the minimum necessary information to only those we feel are in need of your PHI in order to provide health care that is in your best interest.

We support your full access to the personal medical records. You should be aware that we may have indirect treatment relationships with you that include, but are not limited to, laboratories, pharmacies, and other medical offices. As such, we may need to disclose PHI for purposes of treatment, payment and/or other health care operations. These outside entities do not necessarily need to obtain your consent for these communications.

You have the right to refuse to consent to the use of or disclosure of your PHI. This refusal must be made in writing. Under the HIPAA law, we have the right to refuse to treat you if you choose to refuse disclosure of your PHI. If you give consent to disclose your PHI, by signing this document, you can at some future time request to refuse future disclosures of your PHI. This refusal must be made in writing. However, you may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have received a copy of my Patient Privacy Policy. You have the right to review my privacy notice, request restrictions and revoke consent in writing after you have reviewed my privacy notice.

Print Patient Name _____

Patient Signature _____ Date _____