HIPAA PATIENT ACKNOWLEDGMENT AND CONSENT

I have received the Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information and have had an opportunity to read and review all contents of said document. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. These changes may apply to any of your protected health information that we may obtain.

You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect the action we have or will take in reliance to this consent before we received your revocation, and that not signing this consent or by revoking such consent in the future, we may reserve the right to refuse treatment.

Patient's Name: _____ **Date:** _____

Signature: _____

{ If a personal representative on behalf of this patient signs this consent, or is appointed by you as the patient to have shared knowledge of treatment, payment activities, and health care options, please fill out the following information. }

Personal Representative's Name: _____

Relationship To Patient: _____

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____ _____
Name (Printed) *Relationship*

_____ _____
Name (Printed) *Relationship*

_____ _____
Name (Printed) *Relationship*