Patient Consent Form

I understand that, under the health insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to pri 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 i indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and d information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understar the right to change its notice of Privacy Practices from time to time and that i may contact this organization at any time at a current copy of the Notice of Privacy Practices.

I understand that i may request in writing that you restrict how my private information is user or disclosed to carry out trea care operations. i also understand you are not required to agree to my requested restrictions, but if you do agree then you a restrictions.

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

Patient Name *

Relationship to Patient *

Signature

Date

09/14/2023

Send Message

Edit form