

PATIENT CONSENT

Patient's Name: _____ Date of Birth _____

The Department of Health and Human Services has established a 'Privacy Ru privacy. The Privacy Rule was also created in order to provide a standard for ce for uses and disclosures of health information about the patient to carry out to	ertain health care _l	providers to obtain their patients' consent
As our patient we want you to know that we respect the privacy of your personand protect that privacy. When it is appropriate and necessary, we will provide feel are in need of your health care information and information about treatmental that is in your best interest.	de the minimum i	necessary information to only those we
We also want you to know that we support your full access to your personal me (such as laboratories that only interact with physicians and not patients) and purposes of treatment, payment, or health care operations. These entities are	may have to discl	ose personal health information for the
You may refuse to consent to the use or disclosure of you personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you chose to give consent in this document, at some future time you may request to refuse to disclose all or part of your (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.		
If you have any objections to this form, please ask to speak with our HIPAA	Compliance Offic	cer.
You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our Privacy Notice.		
EACH UNDERSIGNED REPRESENTS THAT HE/SHE HAS READ AND FULLY ENTIRE AGREEMENT.	UNDERSTANDS	THE MEANING AND EFFECTS OF THIS
Signature of patient or parent/guardian if mi	nor	Date
Printed name of patient or parent/guardian if mi	nor	Relationship to Patient