HIPPA NOTIFICATION FORM

Consent for use of information and receipt of policy

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected 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 in that treatment directly and 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 disclosures of my health information. I have been given the right to review such Notice of Privacy Practices at any time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing for you to restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions. However, if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent to use my protected health information in writing at any time, except to the extent that you have already taken action relying on this consent.

Signature:_____ Date:_____

Printed name:_____