**HIPAA Compliance Client Consent:**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient’s rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you, however such a revocation will not be retroactive. By signing this form, I understand that:

\_\_\_\_Protected health information may be disclosed or used for treatment, payment, or healthcare operation
\_\_\_\_The practice reserves the right to change the privacy policy as allowed by law.

 \_\_\_\_The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions

\_\_\_\_The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease

\_\_\_\_The practice may condition receipt of treatment upon execution of this consent May we phone you to confirm appointments? YES\_\_\_ NO\_\_\_
May we leave a message on your answering machine at home or on your cell? YES\_\_ NO\_\_ May we leave a message at your employment? YES\_\_\_ NO\_\_\_

May we email to your specified email address personal private health information including but not limited to laboratory reports, treatment, recommendations, relevant scientific articles and medical forms? YES\_\_\_ NO\_\_\_
Would you like a copy of our Notice of Privacy Practices (initial one): YES\_\_\_\_\_NO\_\_\_\_\_

May we discuss your medical condition with any member of your family? YES\_\_\_\_ NO\_\_\_\_

If YES, please name the members allowed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent was signed by: (print name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_

Original document needs be maintained in client’s record.