PRIVACY PRACTICES

Due to the health insurance portability and accountability act, our office is now required to give all patients the ability to obtain a copy of our privacy policy. It informs you how we use and disclose your health information for treatment, payment and healthcare operations. This will be done at patient's request. A copy of our policy will be available in the office reception room, for patients review. Please sign this as your acknowledgement that this office is following HIPPA policy.

Patient Signature **Date**

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. You have a right to read our Notice of Privacy Practices before you decide whether to sign this consent. You will have the right to evoke this consent at any time by giving us written notice of your revocation by certified mail.

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Patient Signature **Date**

Thank you for your cooperation in complying with the Federal HIPPA Regulations. The privacy of your health information is important to us. At your request, we will be happy to provide you with a copy of this consent form.