**HIPAA PRIVACY PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

With my consent {Business Name}, its staff, providers, and associates may send me a text message, email or call my cell/home phone or other designated (by me) contact number to leave me a message in reference to any items that may assist the practice in carrying out my medical care, such as appointment reminders, insurance items or clinical care.

Things I understand:

* Protected health information may be disclosed or used for treatment, payment, or health care operations.
* The Practice has a Notice of Privacy Practices and that I can review this Notice at any time.
* The Practice reserves the right to change the Notice of Privacy Policies.
* The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
* The patient may revoke this consent in writing at any time and all future disclosures will then cease.
* The Practice may condition treatment upon the execution of this Consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

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

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

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Print Name Date

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Signature