HIPAA Patient Consent Form

Please tell us with whom we are allowed to discuss and disclose your personal health information.

NAME:	RELATIONSHIP:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

My signature below authorizes the release of medical information to any specialist I may be referred to and to process insurance claims, prescriptions, and lab work.

I understand that under the HIPPA act, I have certain rights to privacy regarding my protected health information. I understand this information can 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.

The release of my health information and all records be sent to or discussed with any specialist I may be referred to and to process insurance claims, prescriptions, and lab work.

I understand I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment, or health care operations.

Patient Name: _____ Date: _____
Patient Signature: _____
Provider Signature: _____