Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for privacy. The "Privacy Rules" were also created in order to provide a standard for health care providers to obtain their patients' consent for use and disclosure of health information about the patient to carry out treatment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You have the right to review our privacy notices for more complete uses and disclosures before signing this form. You may refuse to consent to the use or disclosure of your personal health care information, but this must be in writing. You also have the right to request restrictions of how your personal health information is used. However, under this law, we have the right to refuse to treat you should you choose to refuse to disclosure of your personal health information (PHI). If you choose to give consent in this document, at some future time you may request to refuse the use of all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any questions on this form, please speak with our office manager.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice. Your signature below acknowledges consent to our privacy policies.

Print Name_____ Date of Birth:_____

Signature_____ Date:_____

If signed by patient representative, please state your relationship to the patient: _____