CONSENT & HIPAA AUTHORIZATION FORM

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent to Treatment: I consent to medical care and treatment by the providers of this clinic.

Authorization to Release Information: I authorize the release of my medical records for purposes of treatment, payment, or healthcare operations.

HIPAA Notice: I acknowledge receipt of the Notice of Privacy Practices outlining my rights under HIPAA.

I understand that my medical information may be shared electronically in compliance with federal regulations.

I may revoke this authorization in writing at any time, except where actions have already been taken based on it.

Signature of Patient/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_