HIPAA Privacy Rule of Patient Authorization Agreement

- Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

- Privacy Rule of Patient Consent Agreement

- Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

Patient Signature:

Patient Name: _____

Date: _____