

## Receipt of Notice of Privacy Practices & Consent Form

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

Patient Phone Number: \_\_\_\_\_

Patient Address: \_\_\_\_\_

**Signing this document signifies that you have received a copy of our Notice of Privacy Practices.**

In the course of providing services to you, we, create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment include (1) our submission of your health information to a billing agent or vendor for processing claims or obtain payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payments; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to preform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*.

You have the right to ask us to restrict the use or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices*.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

\_\_\_\_\_  
Relationship to Patient

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

Source of authority: \_\_\_\_\_