HIPAA Compliance Patient Agreement

Employees and partners of the practice will have access to confidential information, both written and oral, in the course of their employment and job responsibilities. It is imperative that this information is not disclosed to any unauthorized individuals to maintain the integrity of the patient's information. An unauthorized individual would be any person that is not currently an employee of the practice.

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You agree that by signing this consent, you have reviewed our notice before signing this consent.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations. You have the right to revoke this consent in writing, signed by you. However, revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may deny treatment upon execution of this consent.

This consent was signed by: _____
(PRINT NAME PLEASE)

SIGNATURE: _____ **Date:** _____