PATIENT CONSENT FORM (PART 1)

OUR NOTICE OF PRIVACY PRACTICES PROVIDES INFORMATION ABOUT HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOUR RIGHTS UNDER THE LAW. YOU HAVE THE RIGHT TO REVIEW OUR NOTICE BEFORE SIGNING THIS CONSENT. THE TERMS OF OUR NOTICE MAY CHANGE. IF WE CHANGE OUR NOTICE, YOU MAY OBTAIN A REVISED COPY BY CONTACTING OUR OFFICE.

YOU HAVE THE RIGHT TO REQUEST THAT WE RESTRICT HOW PROTECTED HEALTH INFORMATION ABOUT YOU IS USED OR DISCLOSED FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS.

BY SIGNING THIS FORM, YOU CONSENT TO OUR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ABOUT YOU FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. YOU HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, SIGNED BY YOU. HOWEVER, SUCH A REVOCATION SHALL NOT AFFECT ANY DISCLOSURES WE HAVE ALREADY MADE IN RELIANCE ON YOUR PRIOR CONSENT. THE PRACTICE PROVIDES THIS FORM TO COMPLY WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

THE PATIENT UNDERSTANDS THAT:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The practice has a notice of privacy practices and that the patient has the opportunity to review the notice.
- The practice reserves the right to change the notice of privacy policies.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon the execution of this consent.

This consent was **signed** by: _____ Date: _____

Relationship to patient (if other than patient): _____

WITNESS: _____

VERY IMPORTANT
PLEASE READ

YOU HAVE MY PERMISSION TO DISCUSS MY CARE (BIOPSY RESULTS / LAB RESULTS, TREATMENT, ETC.) WITH THE FOLLOWING PEOPLE IF I AM NOT AVAILABLE.

SPOUSE ☐ **Name** _____

FRIEND ☐ **Name** _____

DAUGHTER/SON/P.O.A. ☐ **Name** _____

OTHER ☐ **Name** _____

NONE ☐

SIGN HERE X. _____