PATIENT PRIVACY FORM

Patient's Name: ____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing 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. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

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.
- All other disclosures by the practice will require specific authorization by you unless required by law.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice and receive a copy.
- The Practice reserves the right to change the Notice of Privacy Policies. The new policy will be posted in the lobby and on the web site.
- The patient has the right to restrict the uses of their information **used for treatment, payment or operations**, but the Practice does not have to agree to those restrictions.

This consent was signed by: ____________________________________ Date: ________________

Signature of Patient or Authorized Representative

Relationship to Patient (if other than patient):____

In front of ____

Signature – Practice representative

(Please sign this bottom portion if you would like us to be able to discuss your treatment or financial arrangements with any individuals other than yourself. Please refer to our notice of practices for more details.)

I, ____ as a patient/ guardian of McLain Surgical Arts, authorize the medical information regarding my treatment and care to be discussed with the following individuals.

____ ____________________

Name (please print) Relationship to Patient