

Health Information Consent Form

HIPPA

Patient Name: _____

Please read carefully:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

I **do / do not** wish to receive a full copy of the privacy practices.

I acknowledge that I may request a copy any time in the future by simply calling the office.

Signature: _____ Date: ____ / ____ / _____