[Company Name]

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I _____consent to the use or disclosure of my "protected health information" as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and this Consent by [Company Name] for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of [Company Name]. I understand that diagnosis or treatment of me by _____ **[Name of Physician]** may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including but not limited to my demographic information, collected from me and created or received by my Physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe such information may identify me.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or the healthcare operations of [Company Name]. [Company Name] is not required to agree to any restriction that I may request. If, however, [Company Name] agrees to any restriction requested by me, such restriction shall be binding on [Company Name] and _____ **[Name of Physician]**. I further understand that have the right to revoke this consent, in writing, at any time, except to the extent that _____ **[Name of Physician]** or [Company Name] has taken action in reliance on this Consent.

I understand I have a right to review [Company Name]'s **Notice of Privacy Practices** prior to signing this Consent. [Company Name] 's Notice of Privacy Practices has been provided to me and describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills or in the performance of the health care operations of [Company Name]. This Notice of Privacy Practices also describes my rights and [Company Name] 's duties with respect to my protected health information.

Please also note that as provided in [Company Name] 's Notice of Privacy Practices, [Company Name] reserves the right to change the privacy practices that are described in such notice. I may obtain a revised notice of privacy practices by accessing the [Company Name]'s website, calling the office at [Company Phone] and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative’s Authority

INSTRUCTIONS FOR OFFICE PERSONNEL:

1. Obtaining the patient's consent prior to treating the patient or using information for payment or healthcare operations was made optional in the final Privacy Rule.

2. If the practice elects to continue using the consent form, this consent form must be completed by a patient ***before*** the Physician first sees the patient (with some exceptions such as emergency situations where a consent cannot be obtained beforehand).

3. This document may not be combined with the Notice of Privacy Practices. A separate copy of the Notice of Privacy Practices must be given to the patient ***before*** the Physician sees the patient for the first time (again with some exceptions).

4. HIPAA requires that this office retain an electronic or written copy of this consent form for **six (6) years** from the date it is signed or the date when the consent was last in effect, whichever is later.

5. In the case where the patient's consent is not obtained, such as an emergency situation, and treatment is provided, this office must document its attempt to obtain consent and the reason why consent was not obtained (include the dates on which attempts were made and the method(s) by which you attempted to contact the patient). Such documentation must be included in the patient's written file or stored electronically or both.