

# HIPAA Consent Form

I give this practice my consent to use or disclose my protected information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed I may review the practice's Notice of Privacy Practices (for more complete description of uses and disclosures) before signing this consent form.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notice at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to my request, they must follow the restrictions.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.