HIPAA CONSENT FORM

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 your protected health information is used or disclosed for treatment, payment or healthcare 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 your protected health information about you for treatment, payment and healthcare 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 prior to the date of revocation. SOMSA provides this form to comply with the Health Portability and Accountability Act of 1996 (HIPAA).

I, _____ (patient name) understand that:

- My Protected health information may be disclosed or used for treatment, payment or healthcare operations
  The Practice has a Notice of Privacy Practices and that I have had the opportunity to review this Notice.
- The practice reserves the right to change the Notice of Privacy Policies.
- I have the right to restrict the use of my information, but the Practice (SOMSA) does not have to agree to those restrictions.
- I may revoke this consent, in writing, at any time, and all future disclosures will then cease.
- The Practice (SOMSA) may condition treatment upon the execution of this Consent.

Choices in Privacy (Guidelines):

- ☐ Leave Voicemail
- ☐ Send SMS
- ☐ Talk with Family member
- ☐ Send E-mail
- ☐ **All/Any of the above**

SIGNATURE: _____

(Patient or Legal Representative)

Relationship to Patient: _____

DATE: _____ **In the presence of:** _____