

PATIENT PRIVACY 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 protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree with 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 revocation shall not affect any disclosures we have already made in reliance on your prior consent. Allen C. Richmond MD PC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment or health care operations.
2. Allen C. Richmond MD PC has a Summary Notice of Privacy Practices and that the patient has the opportunity to review this notice.
3. Allen C. Richmond MD PC reserves the right to change the Notice of Privacy Policies.
4. The patient has the right to restrict the uses of their information but Allen C. Richmond MD PC does not have to agree to those restrictions. Any restrictions will be reviewed and the patient will be notified of our final decision.
5. The patient may revoke this consent in writing at any time and all future disclosures will then cease.
6. Allen C. Richmond MD PC may condition treatment upon the execution of the consent.

I give permission to communicate with _____ in regards to my Private Healthcare Information. (Name) (Relationship)

This consent was signed by: _____
(Patient or Representative)

Print Patient Name: _____

Relationship to Patient (if other than patient): _____

In front of _____ Date: _____
(Allen C. Richmond MD PC Employee)

Patient refused to sign. Reason: _____