PATIENT HIPAA CONSENT AND ACKNOWLEDGEMENT FORM

Patient Name: _____

_____ (Patient initials) **Notice of Privacy Practices:** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient initials) **Release of Information:** I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its privacy practices as described in its Notice of Privacy Practices. I may obtain a copy of the Notice of Privacy Practices, including any revisions of that notice, at any time by contacting: Dr. Roy Northcutt | Phone: 217-839-2135 | Address: 709 Staunton Road Gillespie, IL 62033

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Right to Revoke: I understand that I have the right to revoke this consent at any time by giving written notice to the contact person listed above. I understand that revocation of this consent will not affect any action you took in reliance on this consent before you received my revocation, and that you may decline to treat me or to continue treating me if I revoke this consent.

Signature: _____ Date: _____

Relationship to Patient: _____

Persons Authorized to Receive Medical Information: _____

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify): _____