HIPAA Privacy Policy Disclosure and Consent Form

Please read this document carefully before signing. This form acknowledges your receipt of our Notice of Privacy Practices and provides your consent for the use and disclosure of your protected health information (PHI) for treatment, payment, and healthcare operations.

1. Patient Information

Patient Full Name: _____

Date of Birth (MM/DD/YYYY): _____

Phone Number: _____

Email Address: _____

2. Acknowledgment of Notice of Privacy Practices

By signing below, you acknowledge that you have been provided with a copy of our Notice of Privacy Practices, which describes how your medical information may be used and disclosed, and how you can get access to this information.

3. Authorization to Share Information with Family/Friends

I authorize the following individuals to receive information regarding my treatment, billing, or appointments:

Authorized Person 1 (Name): _____ Relationship: _____

Authorized Person 2 (Name): _____ Relationship: _____

4. Consent and Signature

By signing below, I consent to the use and disclosure of my protected health information for treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

Signature of Patient or Legal Representative: _____

Date (MM/DD/YYYY): _____

If Legal Representative, State Relationship to Patient: _____