

HIPAA Disclosure and Patient Registration

Please complete all sections below. This form is designed to be completed and printed for our records.

1. Patient Registration Information

Full Name:

Date of Birth (MM/DD/YYYY):

Gender:

Street Address:

City, State, ZIP Code:

Phone Number:

Email Address:

Emergency Contact Information

Emergency Contact Name:

Relationship to Patient:

Emergency Contact Phone:

2. HIPAA Privacy Disclosure

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) 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.

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 a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

3. Patient Acknowledgement and Consent

I acknowledge that I have received or have been given the opportunity to review a copy of this office's Notice of Privacy Practices.

Patient or Representative Signature (Print Name):

Relationship to Patient (if signed by Representative):

Date (MM/DD/YYYY):