# SHOT PATIENT

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## HIPAA Compliance Patient Consent Form

**Patient:** _____

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. By your signature, you ascertain that you have reviewed our notice before signing the consent.

The terms of the notice may change. If so, you will be notified at your next visit to update your signature date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment and payment.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment and payment.

The practice reserves the right to change he privacy policy as allowed by law

The practice has the right to restrict the use of the information, but the patient does not have to agree to those restrictions.

The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

The practice has the right to obtain information from your medical providers as well as information from HIE CRISP which will help us to better understand your medical history.

May we phone, email, or send a text to you to confirm your appointments? ____ yes ____no

May we leave a message in your voice mail at home or on your cell phone? ____ yes ____ no

May we discuss your medical condition with any member of your family? _____ yes ____ no

If yes, please name the members allowed: _____

Patient Signature: _____ Print Patient Name_____

Parent and or Guardian Signature if patient is a minor: _____