HIPAA CONSENT & ACKNOWLEDGEMENT FORM

Patient Name: _____
Date of Birth: _____
Phone Number: _____

Acknowledgement of Notice of Privacy Practices

I acknowledge that I have been provided with, or have been offered, a copy of this medical office's **Notice of Privacy Practices**, which explains how my protected health information (PHI) may be used and disclosed in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

I understand that this medical office may use and disclose my health information for purposes of **treatment, payment, and healthcare operations** as permitted by law.

Consent for Use and Disclosure of Protected Health Information

By signing this form, I voluntarily consent to the use and disclosure of my protected health information by this medical office for:

- Medical treatment and coordination of care
- Insurance billing and payment activities
- Healthcare operations, including quality assessment and administrative purposes

I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken in reliance on it.

Communication Preferences (Optional)

Please indicate how you prefer to be contacted (check all that apply):

☐ Phone call
☐ Voicemail (messages may include

Authorized access to my records to be included to: _____

Full Name

_____ _____ _____

Relationship Date of birth Contact number

_____ _____

Patient Signature Date