**HIPPA CONSENT**

By signing this form, you consent to my use and disclosure of protected health information

according to the Notice of Privacy Practices. You have the right to revoke this consent at any time, in

writing. However, such a revocation shall not affect any disclosures I have already made in reliance on

your prior consent. I provide this form to comply with the Health Insurance Portability and Accountability

Act of 1996 (HIPAA).

You have the right to request a restriction or limitation on the medical information I use or

disclose about you for treatment, payment, or health care operation. This request must be done in

writing. I will honor your request whenever possible.

The patient understands that:

* I will not release information to any future doctor, attorney, life insurance company, workman's comp company without your written consent.
* Protected health information may be used for treatment through one of your current doctors, payment with your insurance company, or healthcare operations within our office.
* I have a Notice of Privacy Practice that is available for review.
* I reserve the right to change the Notice of Privacy Practices.
* The patient has the right to restrict the use of their information, but I do not have to agree to these restrictions if, for example, it interferes with treatment, payment, or daily operations.
* The patient may revoke this consent in writing at any time and all future disclosures will then cease.
* I may condition treatment upon the execution of this consent.
* You have the right to be notified of a protected health information breach.
* I cannot sell your health information without your permission.
* Certain uses of your medical data, such as the use of patient information in marketing, require prior disclosure and your authorization. Uses and disclosures not described in the Notice of Privacy
* Practice will only be made with your authorization.

I acknowledge that I was provided with a copy of the Notice of Privacy Practices.