
# HIPPA Consent Form

***Please initial each line and sign at the bottom of the page.***

_____ I am aware that the practice has a **Notice of Privacy Practices** that contains a section on Patient Rights. I have been given the opportunity to review this Notice (Effective Date 9/23/13).

_____ I am aware that most standard email/text does not provide a secure means of communication. There is some risk that any protected health information contained in email/text may be disclosed to, or intercepted by, unauthorized third parties. Use of more secure communications, such as phone or fax is an always an alternative that is available to you.

_____ I am aware that I may request restrictions concerning the use of my personal medical information and that my request may not be able to be fulfilled and I will be notified if my request is denied.

_____ Person(s): we may speak with regarding your healthcare: (please list name, relationship, and contact number)

_____

_____

_____

_____ I request restrictions concerning my personal medical information:

_____

_____

_____

**Patient Signature** _____ **Date** _____