NOTICE OF PRIVACY PRACTICES

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that by signing this consent I authorize you to disclose my protected health information to carry out:

-Conduct, pan, and direct my treatment and follow up among the multiple healthcare providers who may be involved in the treatment directly or indirectly.
-Obtain payment from third party payers.
-conduct normal healthcare operations such as quality assessments and physician certificates.

I have been informed of and given the right to review and secure a copy of your notice of privacy practices, which contain a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that this organization has the right to change its terms of this notice from time to time and and I amy contact this organization at the address above at any time to obtain a current copy *Notice of Privacy Practices.*

I understand I have the right to restrict these practices on how my information is used and disclosed to carry out treatment, payments, or healthcare operations. I also understand that you are not required to agree to my request, but if you do agree then you are bound to comply with by such restrictions. I understand I have the right to revoke this consent, in writing, at any time. However, amy use of disclosure prior to the date I revoke this consent is not affected.
Appointment reminders: We may use or disclose your contact information to provide you appointment reminders such as voicemail, text, email or letters and postcards.

Do we have permission to discuss your treatment with **(please circle) Parent Spouse** or **others** _____ **initial**_____
Signed this _____ day of _____. 20_____
Print patient name_____ Signature_____
Responsible party _____ Signature_____