



CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION (HIPAA)

Expiration Date: (NONE)

Section A – Patient Information (Please Print)

Today's Date: _____

Name (First/Mi/Last) _____

SSN#: _____ Birthdate: _____

Home Address: _____

Apt#: _____ City/St/Zip: _____

Telephone No: _____

Alternate Telephone No: _____

E/Mail Address: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify) _____

SECTION B: OUR HIPAA STATEMENT

Please read the following statements carefully

Purpose of Content: By signing this form, you consent to our use and disclosure of your protected health information (PHI) to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your PHI, and of other important matter about your PHI. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your PHI that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Notice of Privacy Practices Contact Person: **Jhonnelle Roberts** Telephone: **404-243-0217 ext 12** Email: **hipaa@rfd-pc.com**

Section C – ACKNOWLEDGEMENT & CONSENT

(SIGNATURE REQUIRED)

NOTE: You are entitled to a signed copy of this Acknowledgement/Consent Form. If a personal representative signs the Acknowledgement/Consent on behalf of the patient, please complete the following:

Personal Representative's Name (Please Print): _____

Relationship to Patient: Parent Grandparent Other _____

➤ **Acknowledgement of Receipt of Notice of Privacy Practice:** I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

➤ **Signature:** _____ **Date:** _____

Patient or Guardian (Must be 18 yrs or older)

➤ **Consent:** I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. **You may** refuse to sign this form, by doing so we may refuse you treatment.

➤ **Signature:** _____ **Date:** _____

Patient or Guardian (Must be 18 yrs or older)

