The Eartheart Institute

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HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this form, I consent to the use and disclosure of my protected health information for the purposes of treatment, payment, and health care operations.

I have been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which provides information about how you may use and disclose my protected health information as well as a more complete description of my rights under HIPAA. I understand that you have the right to change the terms of your Notice and that I may obtain a revised copy by contacting your office or going to your Website.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, billing for services, and health care operations, but that you are not required to agree to these requested restrictions.

I understand that I have the right to revoke this Consent, in writing, at any time. However, such revocation shall not affect any disclosures you have already made in reliance on my prior Consent.

Printed Patient Name: _____

Date: _____

Signature: _____

Relationship to Patient: _____