# HIPAA CONSENT FORM FOR DR. GREG A. ROBERTS

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under law. You have the right review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you. You may revoke your consent at anytime in writing, along with your signature. However, such a revocation shall not affect any disclosures we have already made in reliance on you prior to Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices that the patient has the right to review.
- The Practice reserves the right to change Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

## ACKNOWLEDGEMENT

I also acknowledge that **I have the opportunity to read** a copy of Dr. Greg A. Robert's summary of Privacy Practices if I should desire.

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**Patient Print Name** Date

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**Patient Signature** (Parent/guardian sign **if patient is under 18**) Date

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**Witness** Date