Patient consent form

Use of this form is optional and not required under the HIPAA privacy rule.

### Your Practice Name

Patient Consent for Use and Disclosure   
of Protected Health Information

I hereby give my consent for **[Insert practice name]** to use and disclose

protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

(The Notice of Privacy Practices provided by **[Insert practice name]** describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

**[Insert name of practice]** reserves the right to revise its Notice of Privacy Practices

at any time. A revised Notice of Privacy Practices may be obtained by forwarding a

written request to **[Insert name and address of privacy officer for the practice]**.

With this consent, **[Insert name of practice]** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **[Insert name of practice]** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked “Personal and Confidential.”

With this consent, **[Insert name of practice]** may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **[Insert name of practice]** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **[Insert name of practice]** to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **[Insert name of practice]** may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Print Patient’s Name Date

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Print Name of Patient or Legal Guardian, if applicable

Note: *This document is a template only. It does not reflect the requirements of your state’s laws. You should consult with advisors (your state or local medical or specialty society, or legal or other counsel) familiar with your state’s privacy laws prior to using this document.*

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