HIPAA ACT

Patient Consent Form

Refined by Federal Standard 45 CFR 160, 162, 164

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 consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); Staff, spouse, ect.
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of this practice
- Continue of the operation of this practice in the case of sale, disability or death of Dr. Fernandez

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health insurance information and my rights under HIPAA. I understand that this practice reserves the right to change the terms of the notices from time to time and that you may contact our office for a current copy of this notice.

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

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date that I revoke this consent is not affected.

Signed this _____ day of _____,20_____

Print Name:_____

Relationship to Patient:_____

Signature:_____

I authorize information to be shared with:_____

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