

HIPPA-Dr. Richard Krawczyk

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

Name: _____

Address: _____

Phone number: _____

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care 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 health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change privacy practices, we will issue a revised Notice of Privacy Practice. 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 protected health information 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 our privacy officer. 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. In conjunction with these privacy practices you will need to provide us with the following information:

1. Name of person(s) we may speak to regarding your health (i.e., spouse, child, etc. including phone number).

2. May we leave a message regarding your health or an upcoming appointment on your answering machine/voice mail

Yes _____ no _____

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 use your disclosure of my protected health information to carry out treatment; payment activities and health care operations.

Signature: _____ Date _____