



9954 Liberia Ave
Manassas, VA 20110
703-335-1020

HIPAA Patient Consent Form

Patient Name _____ Birth Date _____

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. This notice contains a Patient Rights section describing your rights under the law. You have the right to 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.

The patient understands and consents that:

- To disclose, as may be necessary, your health information to other healthcare providers (such as referrals to or consultations with other healthcare professionals, laboratories, hospitals, etc.) for your treatment and/or healthcare.
- To request from other healthcare entities (i.e., doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.
- To submit your diagnoses and treatment information to insurance company(s), other agencies, and/or individual(s) for payment of our services.
- We are providing you with the opportunity to read the "Notice of Patient Health Information Privacy Practices" that provides a more complete description of health information uses and disclosures. You have the following rights:
 - The right to read the "Patient Health Information Privacy Practices" prior to signing this consent.
 - The right to request a copy of the "Patient Health Information Privacy Practices" for your own personal use

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made based upon your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The following person(s) may have access to my healthcare information:

1. _____	_____	_____
Name	Relationship	Date
2. _____	_____	_____
Name	Relationship	Date
3. _____	_____	_____
Name	Relationship	Date

*Please note that if you choose not to sign this consent, we cannot release any information about your treatment to a treating physician or your insurance company.

Patient/Guarantor Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Office use only:

- ☐ Patient refused to sign. Reason for patient refusal to sign:

Staff initials _____