O'DONNELL
vein & laser

HIPPA Compliance Patient Consent Form

Our notice of privacy provides information about how we may use or disclose protected health information. You have a right to restrict how your protected health information is used and disclosed for treatment, payment or health care operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations. By signing this consent form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

- My we phone, email or send a text to you to confirm appointments? **YES** **NO**
- May we leave a voice mail on your home or cell phone? **YES** **NO**
- May we discuss your medical condition with any family member? **YES** **NO**

If YES, please name the members allowed?

_____

Patient Name: _____ DOB:_____

Signature:_____ Date: _____

Witness: _____ Date: _____