HIPAA Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment
- Obtain payment from third-party payers
- Conduct normal healthcare operations

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at 420 E. Third Street, Suite 603, Los Angeles, California 90013 to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

☐ Yes, I would like a copy of your Notice of Privacy Practices

☐ No, I would not like a copy of your Notice of Privacy Practices

Patient/Guardian's Signature:____Date:________________

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If signed by other than patient, indicate relationship and reason why patient is unable to sign.