DISCOVERING EXPRESSION
SPEECH & LANGUAGE

HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a 'patient's rights' section describing your rights under the law. You ascertain by your signature below that you fully understand your rights as a patient.

The HIPAA (Health Insurance Portability and Accountability Act) Law of 1996 allows our practice to use or disclose protected health information for treatment, payment and healthcare operations. By signing this form, you fully understand that:

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

Signature of patient (or parent/guardian if under the age of 18):_____

PRINT Patient's Name: _____

PRINT Parent/Guardian's Name: _____

Date: _____

Please indicate (circle) how you would prefer to be contacted (to confirm appointments, etc.):

Leave voicemail

Text message

Email