Patient Consent Form (HIPAA Compliant)

This **Patient Consent Form** ensures that you are fully informed of your privacy rights and the use and disclosure of your medical information, in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Your privacy and trust are important to us.

Patient Information

Full Name:

Date of Birth:

Address:

Notice of Privacy Practices

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices from [Healthcare Provider Name]. I understand how my health information may be used and disclosed.

Consent to Use and Disclosure

By signing below, I authorize the use and disclosure of my protected health information for treatment, payment, and healthcare operations as described in the Notice of Privacy Practices. I understand that:

- I may withdraw this consent at any time in writing, except to the extent that actions have already been taken based on this consent.
- I have the right to refuse to sign this form, which may affect my ability to receive care or services.
- This consent does not authorize the release of information for purposes other than treatment, payment, and healthcare operations unless required by law or with my explicit authorization.

Patient Authorization

I, the undersigned, have read and understood this form. I consent to the use and disclosure of my health information consistent with HIPAA regulations.

Patient/Representative Signature:

Date:

If not patient, relationship to patient:

This form is for sample purposes only. For official use, please consult with legal or compliance professionals to tailor the document to your organization's requirements.