
**PATIENT CONSENT FORM AND ACKNOWLEDGMENT OF
NOTICE OF PRIVACY PRACTICES**

I understand I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand by signing this consent, I authorize **Today's Women's Health Specialists** to use and disclose my protected health information to:

Carry out treatment (including direct and/or indirect treatment by other healthcare providers)

Obtain payment from third party payers, for example my insurance carrier

Carry out day to day healthcare operations of your practice, **Today's Women's Health Specialists**

I have been informed of and given the opportunity to review and secure a copy of your **Notice of Privacy Practices**, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of the notice and I may contact the office at any time to obtain the most current copy of the **Notice of Privacy Practices**.

I understand I have the right to request restrictions on how my protected health information is used and disclosed to carry treatment, payment and health care operations, but that you are not required to agree to the requested restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the revocation is not affected.

Printed Name Patient or legally authorized individual signature

Patient or legally authorized individual signature

Patient's Date of Birth

Date