The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan. Contact your carrier for pricing plans and details.

Patient/Parent/Legal Guardian Signature:_____ Date:_____

HIPPA Compliance Patient Consent

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. The notice is available upon request or can be reviewed in our office. The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. 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 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 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 as 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.

May we phone, email, or send a text to you to confirm appointments? ____ Yes _____ No

May we leave a message on your answering machine at home or on your cell phone? ____ Yes _____ No

May we discuss your medical condition with any member of your family? ____ Yes _____ No

If YES, please provide name, relationship, and number

1._____ 3._____

2._____ 4._____

Patient/Parent/Legal Guardian Signature:_____ Date:_____

Please notify us if you would like a copy of the HIPAA Notice Privacy Practices for your records.