MidState Therapy Associates
Speech & Occupational Therapy For Children and Adults

HIPAA CONSENT FORM

Please tell us with whom we are allowed to discuss and/or disclose your personal health information:

_____	_____	_____
Name	Relationship	Telephone
_____	_____	_____
Name	Relationship	Telephone

I understand that under the HIPAA Act, I have certain rights to privacy regarding my protected health information. I understand this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and healthcare certifications.

I have also been informed of, and given the right to view 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 I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

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

_____
Patient Name

_____ _____
Patient / Responsible Party Signature Date

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