**HIPAA COMPLIANCE AND PATIENT COMMUNICATION 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 that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

Your 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 a revocation will not be retroactive.

By signing this form, I understand that:

* Protected health information may be disclosed for the following reasons: treatment, payment, quality assurance, utilization review, peer review, treatment alternatives, health related benefits and services, individuals involved in your care or payment of your care, as required by law, to avert a serious threat to health or safety, research, military authorities, public health risks, as required by law, law enforcement, or healthcare operations.
* The practice reserves the right to change the privacy policy as allowed by law.
* The practice has 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.

If you believe that your privacy rights as described in this notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Elite Care Family Practice Clinic

314 S 25th Avenue

Hattiesburg, MS 39401

601-255-8808

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. In addition, if you have questions about this Notice, please contact us at the address noted above. You may also file a complaint with the Secretary of the Department of Health and Human Services within 180 days of becoming aware of the act/omission.

May we contact you using the following methods regarding your appointments, health information, evaluation and treatment related to your care? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please list the name and relationship of the members allowed: YES NO

By my signature below, I hereby acknowledge that I have read and understand the information provided on this Consent Form. I understand the risk associated with different methods of communication, especially email, and consent to the communications outlined in this Consent Form.

This consent was signed by:

**(PRINT NAME PLEASE)**

Signature: Date: