Sun Lake Medical Associates
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Lutz, Fl 33548

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. The notice also contains a patient rights section describing your patient rights under the law. You have the right to review this notice before signing the consent. The terms of the notice may change, and if this should occur, you may receive a revised copy by contacting the office.

You have the right to restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in relation to you on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1) Protected health information may be disclosed or used for treatment, payment, or health care operations.
2) The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice.
3) The practice reserves the right to change the notice of privacy practices.
4) The patient has the right to request restricted use of their information, but the practice does not have to agree to those restrictions.
5) The patient may revoke this consent in writing at any time and all future disclosures will then cease.

This consent signed by: _____
Printed Name (Patient or Representative)

_____/_____/_____
Signature **Date**