

## **Consent to Use and Disclosure of Protected Health Information HIPPA FORM**

### **Use and Disclosure of your Protected Health Information**

Your Protected Health Information will be used by \_\_\_\_\_ Dr. Evelyn Ding and staff \_\_\_\_\_, or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

### **Notice of Privacy Practices**

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office.

You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

### **Requesting a Restriction on the Use or Disclosure of Your Information**

You may request a restriction on the use or disclosure of your Protected Health Information.

This office may or may not agree to restrict the use or disclosure of your Protected Health Information.

If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

### **Revocation of Consent**

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

### **Reservation of Right to Change privacy practice**

This office reserves the right to modify the privacy practices outlined in the Notice.

### **Signature**

I have reviewed this consent form and give my permission to this office to use and disclose my health information in accordance with it.

\_\_\_\_\_  
Name of Patient (Print)

\_\_\_\_\_  
Signature of Patient Date

\_\_\_\_\_  
Signature of Patient Representative

\_\_\_\_\_  
Relationship of Patient representative to Patient

\_\_\_\_\_  
Office Representative Date