

GFP

GENEVA FAMILY PRACTICE

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PROTECTED HEALTH INFORMATION (PHI) PATIENT CONSENT FORM

DETAIL OF CONSENT

Your privacy, including the confidentiality of your health information, is very important to us. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information (PHI). The Notice contains a patient rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change, and you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care 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 your protected health information for your treatment, payment and health care operations.

BY SIGNING BELOW, YOU INDICATE UNDERSTANDING THAT

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent

Printed Name

Signature

Date