HIPAA Patient Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for:

1. Treatment: (including direct or indirect treatment by other healthcare providers involved in my treatment).
2. The day-to-day healthcare operations of Sublette County Hospital District.
3. Obtaining payment from third party payers.

I have also been informed of, and given the right to review 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 you reserve the right to change the terms of the notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

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: _____ DOB _____
(Print)

Signature: _____ Date: _____

(Office Personnel)
Witness by: _____ Date: _____
Patient Refused/Neglected to Sign this Document: _____