Walk In Family Medicine Center

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HIPAA Consent Form

By signing this form, you are granting consent to this center to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have the legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

If you would like to share your health care management with someone, please complete below:

I, _____ authorize my physician or his/her representatives to discuss my health care with:

_____ Relationship _____

_____ Relationship _____

Date _____ Signature of Patient_____