CRISTINA F. KEUSCH, M.D., P.A., TELEPHONE NUMBER: 561-368-9455

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. 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. If we change our notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict your protected health information regarding treatment, payment, and health care 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 reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The practice has a Notice of Privacy practice 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 with 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
- For the patient's convenience, the patient may choose to allow the practice permission to leave protected health information on certain answering machines, emails, voicemail, as selected and approved by the patient below

PATIENT NAME:_____DATE:_____
SIGNATURE:_____RELATIONSHIP TO PATIENT:_____

Appointment reminders may be left on my ____**Cell Phone** ____**Home Phone**
____ Check here if you do NOT want messages left

Biopsy results may be left on my **____Cell Phone ____ Home Phone**
____Check here if you do NOT want messages left

Medical information (prescription refills, etc.) may be left on my **____Cell Phone ____ Home Phone**
____Check here if you do NOT want messages left

I allow the release of my health information to the following person(s): (*please print names clearly*)
Name:_____Relationship to Patient:_____
Name:_____Relationship to Patient:_____

By signing, I acknowledge that I will disclose all of my health information known to me at this time and that all of my other personal information is accurate.

Signature:_____Date:_____