Add your logo

HIPAA Client Consent Form

Client Information

I give consent to _____ for the use and disclosure of my Protected Health Information (PHI) for the specific purposes of providing treatment to me, receiving payment for services rendered to me and for general administrative operations of the practice. I understand that I have the right to request restrictions on the use and disclosure of my PHI, but the practice is not required to agree to these restrictions. If the practice agrees with my restrictions, the restriction is binding on the practice. You may contact me for appointment reminders, schedule changes, or other needs by the following methods (fill in only those methods by which you desire to be contacted):

Home Address (Street, City, State, Zip):

1717 Wilson Blvd.
Arlington, VA 22203

Work Address (Street, City, State, Zip):

1600 Pennsylvania Ave.
Washington, DC 20001

Home Phone:

7035555309

Work Phone:

2025555309

Cell Phone:

5715555309

Email:

Bob@gmail.com

☑ **Marketing: Occasionally we send out newsletters, announcements and special occasion cards. If you do not wish to receive these, please check here:**

I have received a copy of the Privacy Policies Notice. I have read the Notice and understand this authorization form. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment, nor will it affect my eligibility for benefits. I also understand that I may revoke this authorization at any time by notifying the practitioner in writing.

Date:

11/16/2019

Type Name (Client or Personal Representative):

Bob Clinton

Relationship to Client and Description of Representative's Authority:

Self

Signature: