Physician's Weight Control and Wellness Center

HIPAA Consent Form

I understand that as part of my health care, **Physician's Weight Control and Wellness Center** originates and maintains records describing my health history, symptoms, examinations, test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment,
- a means of communication among other health professionals who contribute to my care,
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

After reviewing the ***Notice of Privacy Practices*** I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses, including disclosures via fax. Any disclosures would be on an emergency or court ordered basis. Any other disclosures will require written consent from you.

I further understand that the **Physician's Weight Control and Wellness Center** has the right to change their ***Notice of Privacy Practices*** notice in accordance with the Code of Federal Regulations. Should the **Physician's Weight Control and Wellness Center** change the notice it will be posted on the website www.drweightcontrol.com.

I have been provided and have the right to review the ***Notice of Privacy Practices*** that provides a complete description of how my personal information could be used or disclosed before signing this consent.

With whom may we discuss your treatment and medications provided by this office?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I fully understand and ☐ accept ☐ decline the terms of this consent.

I understand that after reviewing the ***Notice of Privacy Practices*** if I should choose to decline the terms of the notice I could be denied treatment at **Physician's Weight Control and Wellness Center**.

_____ _____

Patient's Signature (authorized representative signing for the patient) Date

NOTE: This signed HIPAA Consent Form will remain in your file and considered current.

Yes, I would like to have a copy of this signed HIPAA Consent Form _____
No, I do not need a copy of this signed HIPAA Consent Form (if no, please initial on the line) _____

FOR OFFICE USE ONLY
[ ] Consent received by _____ on _____
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____