

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996. (HIPPA) I understand that by signing this consent I authorize Dr. Jaclynn Spencer's office to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of Dr. Spencer's practice

I have also been informed of and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that Dr. Jaclynn Spencer's office will reserve the right to change the terms of this notice from time to time and that I may contact the office 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 to carry out treatment, payment and health operations; however the office is not required to agree to these requested restrictions. However, if you agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time.

Patient's name

Date signed

Patient or guardian signature

Relationship to patient