Neighborhood Family Care
9764 Holly Springs Rd, Ste 100
Apex, NC 27539

HIPAA CONSENT AND ACKNOWLEDGEMENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a patient rights section describing your patient rights under the law. You have a right to review this Notice before signing this consent. The terms of the 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 how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction but if we do, we shall honor the agreement.

By signing this form, you consent to our use and disclosure of protected health inform about you for:

1. Treatment (including direct and indirect treatment by other health care providers involved in your medical care)
2. Payment from your insurance company or other third party payers
3. The day-to-day health care operations of our Practice

You have the right to revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date you revoke this consent if not affected. The Practice provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

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 Practices and the patient has the opportunity to review this Notice
- the Practice reserves the right to change the Notice of Privacy Practices
- the patient may revoke this consent in writing at any time
- the Practice may condition receipt of treatment upon the execution of this consent

Please provide up the name(s) of family members or other persons, if any, to whom we may release information regarding your general medical condition, financial account or who have permission to pick up information you have requested.

Name: ____________________ Phone # ____________________ Relationship: ____________________

Name: ____________________ Phone # ____________________ Relationship: ____________________

Patient Name: ____________________ **Date of Birth:** ____________________

Signature of Patient or Representative: ____________________

( ) Self ( ) Parent ( ) Legal Gaurdian ( ) Representative under Health Care POA

Date: ____________________