



Two Institutes • One mission

### HIPAA Patient Consent Form

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Today's Date

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. 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 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, however, if we do, we will honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and healthcare operations. You have the right to revoke this consent in writing, signed by you. Such a revocation, however, will not affect any prior consent disclosures authorized by you. EVH provided this form to comply with the HIPAA Health Insurance Portability and Accountability Act of 1996.

**The following has been acknowledged and understood by patient and/ or responsible party:**

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- EVH has a notice of privacy practices available for patient to review at patients request.
- EVH reserves the right to change the notice of privacy practices.
- The patient has the right to restrict the use of the patient's health information; however, EVH is not obligated to agree to those restrictions.
- The patient may revoke this consent with a signed, written request at any time. All disclosures will cease at the time of the revocation is submitted. EVH may condition receipt of treatment upon the execution of this consent.

\_\_\_\_\_  
Responsible Party Name (Print)

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Today's Date

**The patient has given consent to the following disclosure:**

May we contact you via: **Phone:**  Yes  No **Email:**  Yes  No **Text:**  Yes  No

May we leave messages on the patient's: **Cell Phone:**  Yes  No **Home Phone:**  Yes  No

May we discuss your health information with someone other than yourself?  Yes  No

If you answered **Yes for EVH to discuss your health information with someone other than yourself**, please enter the following information for all parties you give consent for EVH to speak with:

Name	Relationship to patient	Phone number(s)

\_\_\_\_\_  
Responsible Party Name (Print)

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Today's Date

\_\_\_\_\_  
EVH Witness Name/Title (Print)

\_\_\_\_\_  
EVH Witness Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Today's Date