PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information.

Therapy Station, Inc. is committed to maintaining the privacy of your protected health information (PHI). Our promise is that your medical records and other PHI will only be released from our practice with a properly executed authorization form from you, the patient, or your representative, except for certain instances. These instances are described in our Notice of Privacy Practices. The notice is available for you to read in our office and you may have a copy if requested. The following are possible ways in which we may use or disclose your PHI: These are only examples. You may read the entire notice by asking any employee for a copy to read.

1. When our medical staff is caring for your child, we will review your child's medical history.
2. Our administrative staff may audit your child's medical records for completeness.
3. We may need to tell your health plan certain information so that we may receive payment for our services.
4. Obtaining payment from third party payers (i.e. Medicaid and/or private insurance).
5. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment.)

You have the right to review the Notice before signing this consent. You have the right to ask us to restrict how we use your PHI. We will provide you with a form on which you can make your written request for restrictions. We do not have to agree to the restriction, but if we do, we are bound by the agreement. We may make changes to the Notice. Upon your request, we will provide you with any revisions.

By signing this form, you consent to our use and disclosure of your protected health information (PHI) as described in our Notice of Privacy Practices. You have the right to revoke this consent in writing. You have the right to accounting of the disclosures of your PHI for other than treatment, payment and health care operations.

I, _____, have been informed and understand my rights regarding the possible ways in which Therapy Station, Inc. may use and disclose my protected health information (PHI).

I have also been informed of and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information (PHI), and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of_____, 20_____.

Print Patient Name: _____ Relationship to Patient: _____

Print Name: _____ Signature: _____