RAVENSWOOD THERAPY GROUP

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HIPAA PATIENT CONSENT FORM

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our Notice of Privacy Practices is available for your review. Please ask your therapist for a copy.

By signing this form, you consent to our use and disclosure of protected health information according to our Notice of Privacy Practices. You have the right to revoke this consent at any time, but it must be done in writing and signed by you. However, such a revocation shall not affect any disclosures we have already made based upon your prior consent. The Ravenswood Therapy Group provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operation. This request must be done in writing. Whenever possible we will honor your request.

The patient understands that:

- We will not release information to any future doctor, attorney, life insurance company, or workman's compensation company without your written consent.
- Protected health information may be used for treatment through one of your current doctors (such as your primary care physician or a specialist referral), payment with your insurance company, or healthcare operations within our office.
- The Ravenswood Therapy Group has a Notice of Privacy Practices that is available for review.
- The Ravenswood Therapy Group reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but Ravenswood Therapy Group does not have to agree to these restrictions if, for example, it interferes with payment, daily operations, or providing quality health care.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Ravenswood Therapy Group may condition treatment upon the execution of this consent (for example, you may be required to pay for your visit at the time of service)

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Signature of Patient or Legal Representative Date

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