HIPAA Acknowledge and Consent Form

I understand that under the Health Insurance Portability & Accountability Act of 1966, I have certain rights to privacy regarding my protected health informatio0n. I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up and care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

Obtain payment from designated third party payers.

Conduct normal healthcare operations such as quality assessments or evaluation and Physician certifications.

I have been informed by you or your Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. It is available in our office in print form or on the office website www.sunrisemedicalaz.com. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right at any time to change its Notice from time to time and that I may contact this organization at any time to obtain a current copy of the Notice. I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions but if the organization does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at my time except to the extent that the organization has taken action relying on this consent.

______________________________________	________________
Patient name	Date of Birth
______________________________________	________________
Patient **OR** legal representative signature	Relationship to patient