**HIPPA Compliance Patient Consent Form**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient’s rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information.

By signing this form, I understand that:

* Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
* The patient has the right to revoke this consent in writing at any time and all full disclosure will then cease.

May we phone, email or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on our cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

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Patient Responsibilites:

* Unexcused absences could result in loss of scholarship funds.
* Fulfilling expectations of working on therapy at home and/or at the Open Gym is an on-going requirement.
* Earning scholarship funds is based on continued communication with the Therapist and progress of the patient.
* LSPF and Rehab clinics can fully utilize and release photos and/or video of therapy.
* Evaluation and filling out of scholarship form does not guarantee scholarship funds.

My signature confirms my understanding of my HIPPA rights and Patient responsibilities.

This consent was signed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (PRINT NAME PLEASE)

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_