Patient's Signature **Date** **Relationship**

HIPPA CONSENT FORM

By signing this form, I am granting consent to Atlas Medical Consultants to use and disclose my protected health information for the purpose of treatment, payment, and health care operations. Notice of Privacy Practices provides more detailed information about how my protected health information can be used. I understand that I have a legal right to review the Notice of Privacy Practices before I sign this consent.

Atlas Medical Consultants has a Notice of Privacy Practices available at the front desk for my use if I so request which more completely describes such uses and disclosures. It is also posted in the waiting room.

I understand that the terms of Notice of Privacy Practices may change and that I may obtain revised notices by mail or by an update on their website.

I understand that I have the right at any time to revoke this consent, provided I do so in writing. However, the services may still use the information to complete any actions that it began prior to my revoking consent and which rely on my protected health information.

I understand that Atlas Medical Consultants may refuse me further service if I revoke the consent.

Patient Name:_______________________________

Patient Signature:____________________________

Date:______________________