REVOLUTION
REHABILITATION, P.C.

HIPPA PATIENT CONSENT FORM

I understand I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent, I authorize Revolution Rehabilitation, P.C. to use and disclose my protected health information to carry out the following:

- Treatment (including direct or indirect treatment by others healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)

I have also been informed of, and given the right to review and secure a copy of the Revolution Rehabilitation, P.C. Notice of Privacy Practices, which contain a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that Revolution Rehabilitation, P.C. reserves the rights to change the terms of this notice at any time and that I may contact Revolution Rehabilitation, P.C. at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent at any time. However, any use or disclosure that occurred prior to the revocation date is not affected.

Printed Name: _____ **Signature:** _____

Date Signed: _____

I wish to be contacted in the following manner **be sure to fill in contact phone numbers**. If you do not accept blocked calls, any return call may be delayed, unless you remove this feature from your phone.