HIPAA Compliance Patient Consent Form

Authorization for Use or Disclosure of Protected Health Information

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

Our notice of privacy provides information about how we may use or disclose protected health information.

By signing this form, you consent to our use and disclosure of your protected healthcare information and you ascertain that you have reviewed our notice before signing this consent.

By signing this form, I understand that:

- I authorize **Medical Supply Inc. (MSI)** to use and disclose my protected health information.
- The information released in response to this authorization may be re-disclosed to other parties as permitted by law.
- The Protected health information may be disclosed or used for medical treatment or consultation, access to billing records or insurance claims payment and other related healthcare purposes as permitted by law.
- The terms of the notice may change at any given time. If so, I will be notified as necessary.
- This authorization for release of information shall be in force and effect and shall cover the period from: **_____ to _____**
- I have the right to revoke this authorization in writing at any time, except to the extent that the information has been released in reliance upon this authorization.
- That my treatment, payment, enrollment or eligibility for benefits will not be conditioned on the signing of this authorization.

Printed name of Patient

Printed name of Legally Authorized Representative

Signature of Patient

Signature of Legally Authorized Representative

Relationship of Legally Authorized Representative to Patient

Date Signed: _____